B 6 21

BIRTH NO. 67 3501

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3501

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BERGHOFF, Francis A.

2. DATE AND HOUR OF DEATH: APRIL 9 67 1 at 11 25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 702
D. STREET ADDRESS (If rural, give location): 1505 ROUNDHILL ROAD #18.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	5/8/09	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Purchasing Agent	Meat Packers	USA - Maryland	USA

13. FATHER'S NAME: Frederick Berghoff

14. MOTHER'S MAIDEN NAME: Sarah A. O'Connor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	212-03-9665	Mrs. Elinor Berghoff	same address

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 181.7 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) GENERALIZED CARCINOMATOSIS well differentiated
DUE TO
(B) Squamous cell CARCINOMA probably from URINARY TRACT.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/6 1967 to 4/9 1967, that (I) (we) last saw the deceased alive on APRIL 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. Berghoff M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/13/1967	New Cathedral Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 11 1967	Robert E. Farley M.D.	Wm J. Tubman & Sons	Baltimore Md.

VS 150-REV. 1/1/65

W-463

BIRTH NO. 67 3502

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3502

1. NAME OF DECEASED (Type or Print): CHARLES S. WIEVARD

2. DATE AND HOUR OF DEATH: 4/7/67 6 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3011 CHRISTOPHER AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-05

D. STREET ADDRESS (If rural, give location): 3011 CHRISTOPHER AVE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5/13/07

9. AGE (In years last birthday): 59

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: EDWARD W. WIEVARD

14. MOTHER'S MAIDEN NAME: JENNIE LAWYER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 705-12-1861

17. INFORMANT: MADELINE C. WIEVARD ADDRESS: 3011 CHRISTOPHER AVE

MEDICAL CERTIFICATION

1B. 161X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of the Larynx

DUE TO

INTERVAL BETWEEN ONSET AND DEATH: 13 months

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from april 5 19 43 to april 7 19 67, that (I) (we) last saw the deceased alive on April 7 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from ~~the causes~~ stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: J. Alessi M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/8/67

23C. PHYSICIAN'S NAME (Type): EDWARD J. ALESSI M.D.

23D. ADDRESS: 6217 HARFORD ROAD

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/11/67

24C. NAME of CEMETERY or CREMATORY: PARKWOOD

24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Robert E. Allenburg Funeral Home, Inc.

ADDRESS: 6009 Harford Rd.

VS 150-REV. 1/1/65

1967 0 0 0 3 5 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-62b

BIRTH NO. 67 3503

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3503

1. NAME OF DECEASED (Type or Print): Mr. William J. Carrick

2. DATE AND HOUR OF DEATH: 4/8/67 | 7:58 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital 2025 West Fayette

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 3504 Clover Ave.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27 33-00

D. STREET ADDRESS (If rural, give location):

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 8/21/1900

9. AGE (In years last birthday): 66

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronics

10B. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Carrick

14. MOTHER'S MAIDEN NAME: Mabel Long

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 220-10-0393A

17. INFORMANT: Mrs. Mildred G. Carrick ADDRESS: 3504 Clover Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkin's Disease

DUE TO: Retroperitoneal

(B)

DUE TO:

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Aspiration pneumonia + acute pulm. edema — days

19A. DATE OF OPERATION: 4-2-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: R.P. Tumor

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-28 1967 to 4-8 1967, that (I) (we) last saw the deceased alive on 4-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Segundino V. Gamoso M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/8/67

23C. PHYSICIAN'S NAME (Type): SEGUNDINO V. GAMOSO M.D.

23D. ADDRESS: 2025 W. Fayette ST - 23 -

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-11-1967

24C. NAME of CEMETERY or CREMATORY: Lorraine Park

24D. LOCATION (City, town, or county) (State): Woodlawn Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Charles E. Talley M.D.

25C. FUNERAL DIRECTOR: G. Howard Storey

ADDRESS: 307 W. Lexington Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-52 3

BIRTH NO. 67 3504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3504

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): (MARY DORN BANKSTAHL) MARY DORN BANKSTAHL

2. DATE AND HOUR OF DEATH: 8 APRIL '67 2¹⁵ p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5411 Summerfield Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore (~~[illegible]~~)
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 5411 Summerfield Ave

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 16 Oct 1873
9. AGE (In years last birthday): 93
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Dorn
14. MOTHER'S MAIDEN NAME: Mary Theresa

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214 16 9894 B.
17. INFORMANT: Mr Louis E. Huegelmeier
ADDRESS: 5411 Summerfield Avenue 21206

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 428.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atherosclerotic Cardio — several years.

DUE TO

(B) Vascular disease

DUE TO

(C) Generalized arterial insufficiency.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Spring 1959 to 8 Apr 1967, that (I) (we) last saw the deceased alive on 5 Apr 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John C. Hyle M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-10-67
23C. PHYSICIAN'S NAME (Type): JOHN C. Hyle M.D.
23D. ADDRESS: 7527 Belair Rd Balto 36 Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/11/67
24C. NAME of CEMETERY or CREMATORY: Most Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.
ADDRESS: BALTIMORE, MARYLAND

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3505 Registered No. 67 3505

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (JOHN WILLIAM WEIBE) WEIBE-JOHN WILLIAM

2. DATE AND HOUR OF DEATH 4/9/67 - 2 PM 2P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: MARYLAND GENERAL HOSPITAL
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE City 21218 9-08
D. STREET ADDRESS (If rural, give location) 508 E. 26th ST.

48

5. SEX M
6. RACE Caucas
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH 08-15-08
9. AGE (In years last birthday) 58
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAPER HANGER
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Wm. C. WEIBE
14. MOTHER'S MAIDEN NAME MABEL S. TAYLOR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-09-3166
17. INFORMANT Mrs. Maude V. Weibe, 30 Village Rd. Pikesville Md. 21208 ADDRESS

MEDICAL CERTIFICATION

1B. 150X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: one week
DUE TO
(B) Tracheal Esophageal fistula
DUE TO
(C) Carcinoma of esophagus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4-6-67 19 to 4-9-67 19, that ~~(I)~~ (we) last saw the deceased alive on 4-9-67 19 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (did ~~not~~) view the body after death.

23A. SIGNATURE Robert M Beazley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED 4-9-67
23C. PHYSICIAN'S NAME (Type) ROBERT M. BEAZLEY M.D.
23D. ADDRESS Maryland Gen'l Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE Apr.13.1967
24C. NAME of CEMETERY or CREMATORY Prospect Hill Cem.
24D. LOCATION (City, town, or county) (State) Towson Md.

25A. DATE REC'D BY HEALTH DEPT. APR 11 1967
25B. NAME OF REGISTRAR Ralph E. Fabrum
25C. FUNERAL DIRECTOR HENRY SANDER & SONS. INC. ADDRESS Baltimore Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

67 003513

5-316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3506 Registered No. 67 3506

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Stafford, Mr. Olin E. (Olin E. Stafford)

2. DATE AND HOUR OF DEATH 4/8/67 11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Maryland General Hospital
(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - 21218 12-04
D. STREET ADDRESS (If rural, give location): 106 E. 20th St.

44

5. SEX: Male
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single - Never Married
8. DATE OF BIRTH: 11/13/89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most productive period of life, if retired): Vice President - retired
10B. KIND OF BUSINESS OR INDUSTRY: Ford Motor Sales unknown
11. BIRTHPLACE (State or foreign country): Maryland Templeville
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Joseph ? Stafford
14. MOTHER'S MAIDEN NAME: unknown Lydia Sapp

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes World War One
16. SOCIAL SECURITY NO.: 217-01-2990
17. INFORMANT: Mrs Virginia LeCompte Clinical Record
ADDRESS: 116 West University Pkwy

MEDICAL CERTIFICATION

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Expanding abdominal aortic aneurysm. — ? 3 months -
(B) DUE TO: As peripheral vascular disease. — unknown -
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic obstructive pulmonary disease

19A. DATE OF OPERATION: 4/7/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abdominal Aortic Aneurysm
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/07/67 1967 to 4/8 1967, that (I) (we) last saw the deceased alive on 4/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fred R. Eilber M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/8/67
23C. PHYSICIAN'S NAME (Type): FRED R. EILBER M.D.
23D. ADDRESS: Maryland General Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/12/67
24C. NAME of CEMETERY or CREMATORY: Sudlersville Cemetery
24D. LOCATION (City, town, or county) (State): Sudlersville Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 Robert E. Farley M.D.
25B. NAME OF REGISTRAR
25C. FUNERAL DIRECTOR: Henry Sander & Sons Inc.
ADDRESS: Baltimore Maryland

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
W- 600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3507 Registered No. 67 3507

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOHNETTE MARIE (BILLIE) WARE

2. DATE AND HOUR PRONOUNCED DEAD April 5, 1967 9:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2223 N. Calvert Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12 04

D. STREET ADDRESS (If rural, give location) 2223 N. Calvert Street

5. SEX Female

6. RACE Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH May 28, 1931

9. AGE (In years last birthday) 35

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Georgia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 323-12-5824

17. INFORMANT Laura Blackwell ADDRESS 446 E. 20th St.

MEDICAL CERTIFICATION

18. E8740

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of Narcotics

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2223 N. Calvert Street 12 04

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) April 5, 1967 m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Ingested overdose narcotics

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE R S Fisher M.D.

EXAMINER'S NAME (Type) Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER [X]
ASSISTANT MEDICAL EXAMINER [ ]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED April 5, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 4/11/67

23C. NAME of CEMETERY or CREMATORY Mt. Calvary Cem.

23D. LOCATION (City, town, or county) Anne Arundel Cty (State) Md.

24A. DATE REC'D BY HEALTH DEPT. APR 11 1967

24B. NAME OF REGISTRAR Robert E. Fisher

24C. FUNERAL DIRECTOR Wm March ADDRESS 928 E. North Ave

VS 151-REV. 1/1/65

N 971,956 7 0 0 3 5 1 8

P-4001

BIRTH NO. 67 3508 (R) BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3508

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Wilbert H. Powell ~~Frank Freeman~~

2. DATE AND HOUR OF DEATH: 10 April 67 | 1:20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 Md. General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 9-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 1923 Oakhill Ave

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7/10/10
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CAB DRIVER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jos. Powell
14. MOTHER'S MAIDEN NAME: Mary O'Donnell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): unk.
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 014-14-3261
17. INFORMANT: Rt. on Adm
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia Pneumonia

DUE TO

(B) K-W Disease

DUE TO

(C) Diabetes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gastric Ulcer

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-30 1967 to 4 April 1967, that (I) (we) last saw the deceased alive on 10 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: D H Griffin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 10 April 67
23C. PHYSICIAN'S NAME (Type): DEAN H. GRIFFIN M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/13/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Anne Arundel County Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Talley M.D.
25C. FUNERAL DIRECTOR: Wm. C. March
ADDRESS: 928 E. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M 3224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3509 Registered No. 67 3509

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MATUSZAK, MR ANTHONY

2. DATE AND HOUR OF DEATH: 4/10/67 7 50 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 103

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 518 S. BELNORD AVE.

5. SEX: male 6. RACE: white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: 2/22/04 9. AGE (In years last birthday): 63 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABOR 10B. KIND OF BUSINESS OR INDUSTRY: ROBINSON OIL CO 11. BIRTHPLACE (State or foreign country): MD. 12. CITIZEN OF WHAT COUNTRY? AMER

13. FATHER'S NAME: JACOB MATUSZAK 14. MOTHER'S MAIDEN NAME: MARY ANNA JAGIERSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: 215072786 17. INFORMANT: FRANCES MATUSZAK ADDRESS: 518 S BELNORD AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) JAUNDICE — 4 months

DUE TO ~~HEPATIC INSUFFICIENCY~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO — unknown 8 months

(C) CA OF LIVER — years (?)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ATRIAL FIBRILLATION

19A. DATE OF OPERATION: 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1 1967 to 4/10 1967, that (I) (we) last saw the deceased alive on 4/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: MYOUNG KYO YANG M.D. Rodelio Lim Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): Rodelio M. Lim M.D. 23D. ADDRESS: Church Home & Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: APR 14 67 24C. NAME of CEMETERY or CREMATORY: HOLY CROSS CEMETERY 24D. LOCATION (City, town, or county) (State): GERMAN HILL RD MD

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 25B. NAME OF REGISTRAR: Ralph E. Taylor M.D. 25C. FUNERAL DIRECTOR: THE DIPPEL BROS INC ADDRESS: 1800 E LOMBARD ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

67 0 0 0 3 5 1 7

C-434 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3510 Registered No. 67 3510

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT C. CALDWELL

2. DATE AND HOUR OF DEATH: 4-7-67 3:57 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE BELVEDERE AT GREENSPRING BALTO, MD, 21215

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-11
D. STREET ADDRESS (If rural, give location): 3704 SEQUOIA AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	NW N	MARRIED	1-25-77	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Agent		MARYLAND	U.S.

13. FATHER'S NAME: Robert L. Caldwell

14. MOTHER'S MAIDEN NAME: Elizabeth Cooper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOSPITAL CHART ADDRESS

MEDICAL CERTIFICATION

1B. 331X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Bronchopneumonia

DUE TO

(B) CVA

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 3-6 1967 to 4-7 1967, that (I) (we) last saw the deceased alive on 4-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-7-67

23C. PHYSICIAN'S NAME (Type): C. VENTURANZA M.D.

23D. ADDRESS: Sinai Hospital, Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 10, 1967

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Arbutus (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Ralph E. Tarbert M.D.

25C. FUNERAL DIRECTOR: Joseph L. Russ ADDRESS: 2222 W. North Ave. Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

E.15 ✓1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3511 Registered No. 67 3511

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVANS Effie U.

2. DATE AND HOUR OF DEATH: 4/5/67 1:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Baltimore 15-10
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3901 W. Barrington Rd BARRINGTON

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH: 6/6/90 9. AGE (In years last birthday): 76 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country): N.C. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Underwood 14. MOTHER'S MAIDEN NAME: Underwood

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 219-12-5431E 17. INFORMANT: Chart ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — 5d
DUE TO

(B)
DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Arterio sclerotic Cardiovascular

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Abdominoperineal reflection

19A. DATE OF OPERATION: 3/31/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca Colon 20A. AUTOPSY? (Yes or No) Pending 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/17/67 19 to 4/5/67 19, that (I) (we) last saw the deceased alive on 4/4/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4/5/67

23C. PHYSICIAN'S NAME (Type): A Bottone M.D. 23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: Apr. 8, 1967 24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cemetery 24D. LOCATION (City, town, or county): Brooklyn (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Joseph L. Russ ADDRESS: 2222 W. North Ave. Baltimore, Md.

VS 150-REV. 1/1/65 1 5 6 7 0 0 0 3 5 1 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C. 5001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3512 Registered No. 67 3512

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William E. Chaney

2. DATE AND HOUR OF DEATH: March 31, 1967 M.

CERTIFICATE AMENDED 4-18-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 317 N. Mount Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 1901
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 317 N. Mount St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	Col	M	4-4-1896	70				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nativ	Gas & Elec.	St. Mary's County	U. S. A.

13. FATHER'S NAME: William Chaney

14. MOTHER'S MAIDEN NAME: Susie Bennett

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212053244

17. INFORMANT: Esther Chaney — ADDRESS: 317 N. Mount ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: over 1-year

DUE TO

(B) Gastro Enteritis — 1-year

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 5 1967 to MAR 31 1967, that (I) (we) last saw the deceased alive on 3/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Douglas Shepperd M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: 3/31/67

23C. PHYSICIAN'S NAME (Type): J. DOUGLASS SHEPPERD M.D., 604 N. FULTON AVE. BALTIMORE 17, MD. M.D.

23D. ADDRESS: J. DOUGLASS SHEPPERD M.D. 604 N. FULTON AVE. BALTIMORE 17, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-5-1967	Mt Auburn Cemt.	

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 11 1967	Ralph E. Farber M.D.	Cooper Funeral Home Joseph L. Cohen	512 N. Carrollton Ave. Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. and Marriage Record of Deceased
4-18-67 M.H.

4-625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3513 Registered No. 67 3513

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William Harrison

2. DATE AND HOUR OF DEATH: April 7, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 60 1101 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 18-02

D. STREET ADDRESS (If rural, give location): 1101 W. Franklin St.

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: Nov. 2, 1879

9. AGE (In years last birthday): 87

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Powells Point N.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas Harrison

14. MOTHER'S MAIDEN NAME: Mary ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mamie B. Jones

ADDRESS: 1101 W. Franklin St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular Disease Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from Jan 15 1955 to April 7 1967, that (I) (we) last saw the deceased alive on April 3 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William H Watts M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-10-67

23C. PHYSICIAN'S NAME (Type): William H Watts M.D.

23D. ADDRESS: 3134 Arlington Ave Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 12, 1967

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.A.

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 319 N Schroeder St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3514 Registered No. 67 3514

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harry Bolden

2. DATE AND HOUR OF DEATH: April 8, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 809 W. Lexington St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 18-01

D. STREET ADDRESS (If rural, give location): 809 W. Lexington St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Colored	Married	July 8, 1917	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver		Balto. Md.	

13. FATHER'S NAME: Harry Bolden

14. MOTHER'S MAIDEN NAME: Maggie Holmes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Eleanor Bolden ADDRESS: 809 W. Lexington St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary thrombosis — Instant

DUE TO

(B) A.C.V.D. — years

DUE TO

(C) died above date

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Asthmatic — years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-13 1963 to 3-13 1967, that (I) (we) last saw the deceased alive on 3-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. Nakazawa M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): HIROSHI NAKAZAWA M.D.

23D. ADDRESS: 521 W. Lexington St #1

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/13/1967	Mt. Auburn Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 11 1967	Robert E. Farley M.D.	Williams Funeral Home	3198 Belmont St

VS 150-REV. 1/1/65

967 0 0 3 5 2 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-5310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3515 Registered No. 67 3515

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Smith, Gregory

2. DATE AND HOUR OF DEATH: 4-11-67 9:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Dukeland Nursing Home 1501 Dukeland St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-05 D. STREET ADDRESS (If rural, give location): 821 N. Bentalow St

5. SEX: male 6. RACE: negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow 8. DATE OF BIRTH: May 24 1893 9. AGE (In years last birthday): 73 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Amelia Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jack Smith 14. MOTHER'S MAIDEN NAME: Marinda Langhon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: 17. INFORMANT: Dukeland Nursing Home ADDRESS: 1501 Dukeland St

MEDICAL CERTIFICATION

1B. 4221

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL ARTERIOSCLEROSIS =
DUE TO C.V.A.

(B) ARTERIOSCLERCTIC CARDIO-VASCULAR DISEASE
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-11 1967 to 4-11 1967, that (I) (we) last saw the deceased alive on 4-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas W. Harris M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): THOMAS W. HARRIS M.D. 23D. ADDRESS: 1824 W. Franklin St Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/14/67 24C. NAME of CEMETERY or CREMATORY: Chester Cem. 24D. LOCATION (City, town, or county) (State): Amelia Va.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Williams Funeral Home ADDRESS: 3199 N. Schroeder St

VS 150-REV. 1/1/65

967 0 0 3 5 1 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
K-500

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3516 Registered No. 67 3516

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLEN KEENE

2. DATE AND HOUR PRONOUNCED DEAD: April 7, 1967 12:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-08

D. STREET ADDRESS (If rural, give location): 626 Allendale Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: March 14 1915

9. AGE (In years last birthday): 51

If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Tom Reb

14. MOTHER'S MAIDEN NAME: Mary Chaplan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-18-3737

17. INFORMANT: Delmar Rem Sam ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial Infarction

DUE TO

(B) Coronary Artery Thrombosis

DUE TO

(C) Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-12-67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem

23D. LOCATION (City, town, or county) (State): Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

24B. NAME OF REGISTRAR: Robert E. Farley MD

24C. FUNERAL DIRECTOR: Elroy W. Wilson

ADDRESS: 1000 Brantley Ave

VS 151-REV. 1/1/65

1967 0 0 3 5 2 4

M-320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3517 Registered No. 67 3517

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph R. Matthews

2. DATE AND HOUR OF DEATH: April 9 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-06
D. STREET ADDRESS (If rural, give location): 1709 Rutland Ave RUTLAND AVE.

5. SEX: Male
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Jan 6 1919
9. AGE (In years last birthday): 48
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rowen Copper Works
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Matthews
14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-05-5392
17. INFORMANT: Gladys Matthews
ADDRESS: Same

MEDICAL CERTIFICATION

18. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory Insufficiency — 1 week
DUE TO
(B) Carcinoma of Lung — 4 months
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 01/23/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Lung
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): No
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): No

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from December 1966 to 3/22 1967, that (I) (~~last~~) last saw the deceased alive on 3/22 1967 and that in (my) (~~last~~) opinion death occurred on the date and ~~hour~~ and from the causes stated above. (I) (~~Was~~) (~~Did~~) (did not) view the body after death.

23A. SIGNATURE: Robert J. Wilder, M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): Robert J. Wilder, M.D.
23D. ADDRESS: 1801 Eutaw Place, Baltimore, Md. 21217

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: Arlington Cem
24D. LOCATION (City, town, or county) (State): Laurel Md

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: R. E. Farley M.D.
25C. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536

BIRTH NO. 67 3518

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3518

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Cora Anderson

2. DATE AND HOUR OF DEATH: 4-10-67 3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 16-02

D. STREET ADDRESS (If rural, give location): 1009 Woodyear Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH:

9. AGE (In years last birthday): 64 yrs.

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rose Craig - friend

ADDRESS:

MEDICAL CERTIFICATION

18. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: from 4-9-67

DUE TO

(B) Old CVA — to 4-10-67

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 9, 1967 to April 10, 1967, that (I) (we) last saw the deceased alive on April 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: LIZARAZO M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-10-67

23C. PHYSICIAN'S NAME (Type): LIZARAZO M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/12/67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cemetry

24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Richard E. Lafayette

25C. FUNERAL DIRECTOR: AdolphusHalstead

ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

3536

C-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3519 Registered No. 67 3519

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Jane T. Green

2. DATE AND HOUR OF DEATH: April 9, 1967 | 2:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1526 Latrobe Park Terrace Baltimore, Md. 21230

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 24-01
D. STREET ADDRESS (If rural, give location): 1526 Latrobe Park Terrace

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Married	2/1/1917	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	--------	Maryland	~~U.S.A.~~

13. FATHER'S NAME: Adam Trawinski

14. MOTHER'S MAIDEN NAME: Frances Jackowski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): -------

16. SOCIAL SECURITY NO.: ------

17. INFORMANT: Paul J. Green, Sr.

ADDRESS: 1526 Latrobe Park Terrace

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertensive Cardiac Disease — 2 yrs.

DUE TO

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1950 to April 9 1967, that (I) (we) last saw the deceased alive on April 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.

23A. SIGNATURE: Morris B. Schreiber M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-10-67

23C. PHYSICIAN'S NAME (Type): MORRIS B. SCHREIBER M.D.

23D. ADDRESS: 1519 W. Lombard St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/12/67	Holy Rosary Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 11 1967	Robert E. Fahrney	Charles L. Stevens Funeral Home, Inc.	1501 East Fort Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
L-220

67 3520

BIRTH NO. 65-26082

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3520

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOYCE LUCAS

2. DATE AND HOUR PRONOUNCED DEAD: April 8, 1967 10:02 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-04
D. STREET ADDRESS (If rural, give location): 1816 E. Eager Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: Oct 18-1965
9. AGE (In years last birthday): 1
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Lucas
14. MOTHER'S MAIDEN NAME: Betty Armington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Betty Armington
ADDRESS: Same

MEDICAL CERTIFICATION

1B. E9160

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Massive Body Burns and Carbon Monoxide Intoxication.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1816 E. Eager Street 7-04

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 8 (Year) '67 (Hour) A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fire in home.

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-11-67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Elroy O Wilson
ADDRESS: 1001 Brentlyle

VS 151-REV. 1/1/65

N 94 P. 96 / 0 0 0 3 5 2 8

G-642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3521 Registered No. 67 3521

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William M. Grolock

2. DATE AND HOUR OF DEATH: 10 April 67 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 16 Md. Gen'l Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTO~~ Timonium 53-00
D. STREET ADDRESS (If rural, give location): 211 Burning Tree Rd.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 9/4/90
9. AGE (In years last birthday): 76 — If Under 1 Yr. Months / Days / Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGRAVING DEPT. - SUPERINTENDENT
10B. KIND OF BUSINESS OR INDUSTRY: NEWSPAPER PUBLISHING CO.
11. BIRTHPLACE (State or foreign country): BALTO Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Augusta~~ GUSTAV Grolock
14. MOTHER'S MAIDEN NAME: AUGUSTA Discher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): WW1 (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-03-2458
17. INFORMANT: daughter — ADDRESS: on file

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hypoxia
DUE TO
(B) Pulmonary Fibrosis
DUE TO
(C) Pulmonary Tuberculosis
DUE TO
(D) ASHD

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Prostatic Hypertrophy - Suprapubic prostatectomy

19A. DATE OF OPERATION: 3-23-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Prostatic Hypertrophy
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-11 19 67 to 10 April 19 67, that (I) (we) last saw the deceased alive on 4-10-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 10 Apr. 1967
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: APRIL 13, 67
24C. NAME of CEMETERY or CREMATORY: PARKWOOD CEMETERY
24D. LOCATION (City, town, or county) (State): PARKVILLE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: WM. COOK-BROOKS TOWSON — ADDRESS: 7058 YORK ROAD TOWSON, MD 21204

VS 150-REV. 1/1/65

3521

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3522 Registered No. 67 3522

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MATILDA E. MILLER

2. DATE AND HOUR OF DEATH: 4/6/67 | 9 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2334 JEFFERSON ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-03
D. STREET ADDRESS (If rural, give location): 2334 JEFFERSON ST.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	WIDOWED	JAN. 8, 1909	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ALBERT MEINSCHEIN

14. MOTHER'S MAIDEN NAME: BERTHA MILLS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Hartley Miller — ADDRESS: 2334 Jefferson St.

MEDICAL CERTIFICATION

1B. 124X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Edema — 3 days

DUE TO

(B) Carcinomatosis — 6 mos.

DUE TO

(C) Carcinoma of Uterus — 2 yr.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from June 1966 to 4/6 1967, that (I) (we) last saw the deceased alive on 3/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert C Duvall M.D. — Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/6/67

23C. PHYSICIAN'S NAME (Type): R. C. DUVALL M.D.

23D. ADDRESS: 101 W. READ ST. BALTO MD

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-10-67

24C. NAME of CEMETERY or CREMATORY: OAK LAWN CEMETERY

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE RECD BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: John R. Miller Funeral Home — ADDRESS: 2334 Jefferson St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

T-5121

BIRTH NO. 67 3523

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3523

1. NAME OF DECEASED (Type or Print): Sarah Jones Thompson

2. DATE AND HOUR OF DEATH: April 7, 1967 | 11:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-11

D. STREET ADDRESS (If rural, give location): 3402 Dennlyn Road

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: March 31, 1876

9. AGE (In years last birthday): 81

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Montgomery County, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Jones

14. MOTHER'S MAIDEN NAME: Henrietta Stewart

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-54-1133

17. INFORMANT: Mrs. Margaret Hite

ADDRESS: 3402 Dennlyn Rd

MEDICAL CERTIFICATION

1B. 4.2011 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Coronary thrombosis

DUE TO

(B) Arteriosclerosis

DUE TO

(C) senility

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 1965 to April 1967, that (I) (we) last saw the deceased alive on April 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William G. Polk M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4.9.67

23C. PHYSICIAN'S NAME (Type): William G. Polk M.D.

23D. ADDRESS: 1141 N. Fulton Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/10/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State): Arbutus Balto Co., Md

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 Robert E. Tankey M.D.

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Herbert E. Nutter

ADDRESS: 3035 W. North Ave

VS 150-REV. 1/1/65

1 9 6 7 0 2 0 3 5 3 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3524 Registered No. 67 3524

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Smith Sidney

2. DATE AND HOUR OF DEATH: 4/7/67 9:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-04
D. STREET ADDRESS (If rural, give location): 1935 CLIFTON AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	NEGRO	MARRIED	12-24-82	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Custodian	Equitable Trust Co	Baltimore, Md	U S.A

13. FATHER'S NAME: Spriggs Smith

14. MOTHER'S MAIDEN NAME: Susan ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-01-1580	Mrs. Susie Hamlett	1935 Clifton Ave

MEDICAL CERTIFICATION

1B. 433.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cardiac arrhythmia
DUE TO
(B) with intrapulmonary
DUE TO
(C) hemorrhage

INTERVAL BETWEEN ONSET AND DEATH: 3-6 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4/5 1967 to 4/7 1967, that (I) (~~we~~) last saw the deceased alive on 4/7 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David S Fedson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/7/67

23C. PHYSICIAN'S NAME (Type): D S Fedson M.D.

23D. ADDRESS: The Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	4/11/67	Mount Auburn Cemetery	Baltimore,	Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 11 1967	Charles E. Farkuna	Herbert E. Nutter	3035 W. North Ave

VS 150-REV. 1/1/65

3552

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance for the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-93-40 1B H-525 67 3525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3525

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HINKSON, JAMES

2. DATE AND HOUR OF DEATH: 4-8-67 — 3:40A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND #21224 — 31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — 16-01
D. STREET ADDRESS (If rural, give location): 633 CARROLTON AVENUE, #21217

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-20-89
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Red Cap
10B. KIND OF BUSINESS OR INDUSTRY: Penna Railroad
11. BIRTHPLACE (State or foreign country): WEST INDIES
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ? ? ?
14. MOTHER'S MAIDEN NAME: ? ? ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 717-07-7505
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE #21224
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA-R hemiplegia — 3 wks

DUE TO

(B) ? Aspiration Pneumonitis

DUE TO

(C) Urinary Obst + inf.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-22 19 67 to 4-8 19 67, that (I) (we) last saw the deceased alive on 4-8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard Maffezzoli M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-8-67
23C. PHYSICIAN'S NAME (Type): DR. RICHARD MAFFEZZOLLI M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD. #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/13/67
24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Arbutus Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Herbert E. Nutter
ADDRESS: 3035 W. North Ave

VS 150-REV. 1-1965

67 0 3 5 3 3

B-60

BIRTH NO. 67 3526

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3526

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ALICE C. BERRY

2. DATE AND HOUR OF DEATH: 4-8-67 | 6:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3107 WALBROOK AVE.

5. SEX: FEMALE
6. RACE: NEGROID
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 10-13-1901
9. AGE (In years last birthday): 65
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): St. Mary's County, Md
12. CITIZEN OF WHAT COUNTRY?: U.S.A
13. FATHER'S NAME: JOHN BROWN
14. MOTHER'S MAIDEN NAME: SUSIE SMITH
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-32-2011
17. INFORMANT: Mr. Henry T. Young
ADDRESS: 3107 Walbrook Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 600.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Probable intracranial hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO: Hypertension

(C): Chronic nephropathy

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cancer, probable metastatic carcinoma

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/7 19 67 to 4/8 19 67, that (I) (we) last saw the deceased alive on ____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth L. Brigham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/8/67
23C. PHYSICIAN'S NAME (Type): Kenneth L. Brigham M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/67
24C. NAME of CEMETERY or CREMATORY: Mount Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Louis E. Fahrney
25C. FUNERAL DIRECTOR: Herbert E. Nutter
ADDRESS: 3035 W. North Ave

VS 150-REV. 1/1/65

3 5 3 4

M-316

BIRTH NO. 67 3527

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3527

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): William Ellwood Medford

2. DATE AND HOUR OF DEATH: April 9, 1967 | 1:55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218 27-09

D. STREET ADDRESS (If rural, give location): 1430 Northgate Rd.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/26/98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: USN

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E Medford

14. MOTHER'S MAIDEN NAME: Medora Chambers Gorsuch

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): USN 1917-1952

16. SOCIAL SECURITY NO.: 219-16-0668

17. INFORMANT: Records- US PHS Hospital, Balto, Md.

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 450.0 I 7-147X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) XXXXX	Arteriosclerosis, generalized	Years
(B) XXXXX	Pulmonary embolus	Hours
(C)	Carcinoma of the pyriform sinus	Months

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 24 19 67 to Apr. 9 19 67, that (I)(we) last saw the deceased alive on Apr. 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael E. Pelczar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): Michael E. Pelczar, SA Surgeon (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/12/67.

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Paul E. Falkenham

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS:

RGB

VS 150-REV. 1/1/65

1967 0 0 0 3 5 3 5

W-16 D

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3528

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3528

1. NAME OF DECEASED (Type or Print): Jeannette T. Weber

2. DATE AND HOUR OF DEATH: 4/10/67 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore MD
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21224 26-05
D. STREET ADDRESS (If rural, give location): 6014 Eastern Avenue

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5/22/13
9. AGE (In years last birthday): 53
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk--Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E. C. Farmer
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-12-2124
17. INFORMANT: Mr. Bernard G. Weber
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONset AND DEATH

(A) 1) Hepatic Insufficiency — 3 days
DUE TO
(B) 2) ~~Post-op~~ Acute renal failure — "
~~DUE TO~~
due to (C) Post-necrotic Cirrhosis — about 10 years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/7/67 19 to 4/9/67 19, that (I) (we) last saw the deceased alive on 4/9/67 (Apr) 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: A-U Haq M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: April 10, 1967.
23C. PHYSICIAN'S NAME (Type): AZHAR-UL-HAQ M.D.
23D. ADDRESS: Sinai hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/13/67.
24C. NAME of CEMETERY or CREMATORY: Oaklawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

67 B 3536

H-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3529 Registered No. 67 3529

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGARET E. HEIL

2. DATE AND HOUR OF DEATH: April 10-67 9 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-07 D. STREET ADDRESS (If rural, give location): 2210 PINEWOOD AVE

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M 8. DATE OF BIRTH: 09-11-93 9. AGE (In years last birthday): 73 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country): Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM H. WICKER 14. MOTHER'S MAIDEN NAME: Katherine Pfisterer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 212018795 17. INFORMANT: Dr. Ronald W. Heil ADDRESS: 1202 Havenwood Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No): NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 04-07 1967 to 04-10 1967, that (I) (we) last saw the deceased alive on 04-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zoltan Zarday M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 04-10-67

23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY, M.D. 23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/13/67 24C. NAME of CEMETERY or CREMATORY: Western Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: 5305 Harford Rd.

VS 150-REV. 1/1/65 1967 003537

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H-241

BIRTH NO. 67 3530

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3530

1. NAME OF DECEASED (Type or Print): FRANK HASSELBARTH, Jr.

2. DATE AND HOUR PRONOUNCED DEAD: April 10, 1967 9:18 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02

D. STREET ADDRESS (If rural, give location): 5112 Frankford Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8/8/1936

9. AGE (In years last birthday): 30

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Ervin Hasselbarth, Sr.

14. MOTHER'S MAIDEN NAME: Anna T. Hladky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213361004

17. INFORMANT: Mrs. Sandra Irene Hasselbarth-Same ADDRESS:

MEDICAL CERTIFICATION

1B. E8164

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Northern Parkway west of Jones Falls Expressway 22-19

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4-10-67 7:30 A.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Driver in auto-auto collision

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [XX]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: April 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/15/67

23C. NAME of CEMETERY or CREMATORY: Moreland Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

24B. NAME OF REGISTRAR: Robert E. Fallon

24C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: 5305 Harford Rd.

VS 151-REV. 1/1/65

N869670003530

K-230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3531 Registered No. 67 3531

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Kuchta, Feodor

2. DATE AND HOUR OF DEATH: April 8, 1967 | 6 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 80 707 S. East Avenue Baltimore, Maryland 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 707 S. East Avenue #5

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 8/15/96
9. AGE (In years last birthday): 70
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Man
10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Kuchta
14. MOTHER'S MAIDEN NAME: Anna

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-07-8608
17. INFORMANT: Ida Kuchta (nee Augustynowica), wife
ADDRESS: 707 S. East Avenue #5

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 15.3.8 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Colon — 2 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1/31/58 19 to 4/8/67 19, that (I) (~~we~~) last saw the deceased alive on 4/3/67 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Max Baum M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): Dr. Max Baum M.D.
23D. ADDRESS: 7422 Eastern Avenue

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/11/67
24C. NAME of CEMETERY or CREMATORY: Holy Trinity Cemetery
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Schimunek Funeral Home
ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-160

BIRTH NO. 67 3532

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3532

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Neubauer, Lillie E.

2. DATE AND HOUR OF DEATH: April 8, 1967 | 7:40 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
00 516 S. Robinson Street
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1-02
D. STREET ADDRESS (If rural, give location): 516 S. Robinson Street #24

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 3/20/91
9. AGE (In years last birthday): 76 yrs.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Kelch
14. MOTHER'S MAIDEN NAME: Elizabeth Shoemaker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: George Neubauer, above, son
ADDRESS

MEDICAL CERTIFICATION

18. 420.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 5 1967 to April 8 1967, that (I) (~~we~~) last saw the deceased alive on April 8 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Melito R. Torres, M.D. M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-10-67

23C. PHYSICIAN'S NAME (Type): Dr. Melito Torres M.D.
23D. ADDRESS: 441 S. Ellwood Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/12/67
24C. NAME of CEMETERY or CREMATORY: Glen Haven Cemetery
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Ralph E. Falkenna
25C. FUNERAL DIRECTOR: Schimunek Funeral Home
ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

0 0 0 3 5 4 0

H-513

BIRTH NO. 67 3533

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3533

1. NAME OF DECEASED (Type or Print): TROY D. HAMPTON

2. DATE AND HOUR OF DEATH: April 8, 1967 | 1 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 4003 Pinedale Drive #36

5. SEX: M
6. RACE: CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/23/19
9. AGE (In years lost birthday): 48 yrs
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dukes Motel
10B. KIND OF BUSINESS OR INDUSTRY: Self Employed Motel
11. BIRTHPLACE (State or foreign country): Allentown, Pa.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Troy Hampton Sr.
14. MOTHER'S MAIDEN NAME: Martha Ducher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes
(If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: Eva Hampton, wife, above
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/31/67 19 to 4/8 19 67, that (I) (we) last saw the deceased alive on 4/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert P. Doyle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/8/67
23C. PHYSICIAN'S NAME (Type): Dr. Robert P. Doyle M.D.
23D. ADDRESS: The Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Entombment
24B. DATE: 4/12/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Foxley M.D.
25C. FUNERAL DIRECTOR: Schimunek Funeral Home
ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-03-22 IW

F-65367 3534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 3534

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lester JOHN L. FRIEND

2. DATE AND HOUR OF DEATH: 4-7-67 3:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-34

D. STREET ADDRESS (If rural, give location): 1142 HEWITTWAY - 21205

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6/4/04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector

10B. KIND OF BUSINESS OR INDUSTRY: State Roads Comm.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN A. Friend

14. MOTHER'S MAIDEN NAME: STELLA Rhodaver

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 176-03-2650

17. INFORMANT: Carolyn Friend, wife, above ADDRESS: RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA — 12 hours

DUE TO

(B) HASCVD — over 20 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4-7 1967 to 4-7- 1967, that (I) (~~we~~) last saw the deceased alive on 4-7 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David J. Mishelevich M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-7-67

23C. PHYSICIAN'S NAME (Type): DAVID J. MISHELEVICH M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Balto. Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/11/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home

ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

3542

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-614

BIRTH NO. 67 3535

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3535

1. NAME OF DECEASED (Type or Print): Herbert W. Trevillian

2. DATE AND HOUR OF DEATH: 4-9-67 | 3:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1327 S. Charles St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: Aug. 16, 1914
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Finisher
10B. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert Trevillian
14. MOTHER'S MAIDEN NAME: Rosa Dean

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Clyde Rowley
ADDRESS: 4141 Doris Ave. 25

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: SEVERAL MINUTES TO HOURS

DUE TO

(B) OLD PULMONARY TUBERCULOSIS — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-29- 1967 to 4-9- 1967, that (I) (we) last saw the deceased alive on 4-9- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-9-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4 12 67
24C. NAME of CEMETERY or CREMATORY: Balto. U. S. National
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Mc Cully
ADDRESS: 130 E. Fort Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 003543

M-45

BIRTH NO. 67 3536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3536

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MULLINIX, OSCAR G.

2. DATE AND HOUR OF DEATH: 4-7-67 12:05 a.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 24-01
D. STREET ADDRESS (If rural, give location): 1357 Hull St. 21230

5. SEX: M. 6. RACE: W H. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced 8. DATE OF BIRTH: 4/29/1896 9. AGE (In years last birthday): 70 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Checker 10B. KIND OF BUSINESS OR INDUSTRY: Feed Mill 11. BIRTHPLACE (State or foreign country): Baltimore - Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT Mullinix 14. MOTHER'S MAIDEN NAME: Annie Cain

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 1 16. SOCIAL SECURITY NO.: 705-10-3223 17. INFORMANT: Mrs. Roby Pickett ADDRESS: Sykesville, Md.

MEDICAL CERTIFICATION

1B. 422.1 I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — 38 days

DUE TO

(B) A.S.C.V.D.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 3/15/67 19 to 4/7/67 19, that ☒ (we) last saw the deceased alive on 4/7/67 19 and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David J. Steinbauer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 4/7/67

23C. PHYSICIAN'S NAME (Type): DAVID J. STEINBAUER M.D. 23D. ADDRESS: S.B.G.H. 1213 Light Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/10/1967 24C. NAME of CEMETERY or CREMATORY: Prospect Cemetery 24D. LOCATION (City, town, or county) (State): Frederick Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967 25B. NAME OF REGISTRAR: Robert E. Fahrney 25C. FUNERAL DIRECTOR: C. M. Waltz ADDRESS: Box 241 Sykesville, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-645

BIRTH NO. 67 3537

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3537

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Mary G. Karlinsey

2. DATE AND HOUR OF DEATH: April 9, 1967 | 5:05 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Balto. Gen. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-03

D. STREET ADDRESS (If rural, give location): 1728 Clarkson St.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: May 10, 1902

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Belgium

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Fred Browett

14. MOTHER'S MAIDEN NAME: Anna Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Elsie Lilly

ADDRESS: 1728 Clarkson St.

MEDICAL CERTIFICATION

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Heart disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/30 1966 to 4/9 1967, that (I) (we) last saw the deceased alive on 3/29/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Rubin M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): Samuel Rubin, M.D.

23D. ADDRESS: 203 E. Patapsco Avenue Baltimore, Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4 13 67

24C. NAME of CEMETERY or CREMATORY: Mc Dowell

24D. LOCATION (City, town, or county) (State): Green Town Ship, Indiana Co. Pa.

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: R. G. E. Fochaux

25C. FUNERAL DIRECTOR: Mc Cully

ADDRESS: 130 E. Fort Ave

VS 150-REV. 1/1/65

0 3 5 4 5

E-350

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3538

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3538

1. NAME OF DECEASED (Type or Print): EFFIE IRENE EATON

2. DATE AND HOUR OF DEATH: APRIL 9, 1967 12:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 341 S. BENTALOU ST.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-05
D. STREET ADDRESS (If rural, give location): 341 S. BENTALOU ST.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: NOV. 16, 1882
9. AGE (In years last birthday): 84
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: R. F. HIGGS
14. MOTHER'S MAIDEN NAME: MARGARET A. HOFFMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO. 231-62-5644 218-10-7284D
17. INFORMANT: ED. B. EATON
ADDRESS: 341 S. BENTALOU ST.

MEDICAL CERTIFICATION

1B. 4 22 1

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Cardiac Failure — 1 da
DUE TO
(B) Generalized Arteriosclerosis — 5 yrs
DUE TO
(C) Cardiovascular Disease — 5 yr
Generalized Arthritis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/10 1966 to 4/9 1967, that (I) (we) last saw the deceased alive on 4/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph A. Laukaitis MD M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): JOSEPH A. LAUKAITIS MD M.D.
23D. ADDRESS: 679 Washington Blvd Baltimore Md

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: NEW MARKET CEMETERY
24D. LOCATION (City, town, or county) (State): NEW MARKET, VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Talley M.D.
25C. FUNERAL DIRECTOR: GEO. L. SCHWAB FUNERAL HOME
ADDRESS: Francis W. Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

1967 0 0 3 5 4 6

L-350

BIRTH NO. 67-06302 67 3539

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3539

1. NAME OF DECEASED (Type or Print) Michael Joseph Layton — Michael Joseph Layton

2. DATE AND HOUR OF DEATH 4/8/67 | 6 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 University Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Newborn A.A.Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Glen Burnie - 52-00

D. STREET ADDRESS (If rural, give location) 101 Cedarcliff Court

5. SEX M

6. RACE W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married

8. DATE OF BIRTH 3/31/67

9. AGE (In years last birthday) — If Under 1 Yr. Months Days: 8 days — If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn

10B. KIND OF BUSINESS OR INDUSTRY →

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Layton

14. MOTHER'S MAIDEN NAME Barbara Wayson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Chad — ADDRESS

MEDICAL CERTIFICATION

18. 754.7 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Truncus arteriosus — 8 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/5 19 67 to 4/8 19 67, that (I) (we) last saw the deceased alive on 4/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Martha Leffler M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 4/8/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-10-1967

24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park

24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT. APR 11 1967

25B. NAME OF REGISTRAR Robert E. Farley M.D.

25C. FUNERAL DIRECTOR George J. GONCE, 4001 Ritchie Hgwy., Baltimore — ADDRESS

VS 150-REV. 1/1/65

67 0 3 5 3 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G 1 645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3540 Registered No. 67 3540

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) [redacted] MINNA D. GROLMAN

2. DATE AND HOUR OF DEATH 4/5/67 5.23 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp. 33rd & Calvert St Balt. Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-15
D. STREET ADDRESS (If rural, give location) 6509 BAYTHORNE ROAD

5. SEX F
6. RACE Caucasian
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married
8. DATE OF BIRTH 8/11/94
9. AGE (In years last birthday) 72
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY
10B. KIND OF BUSINESS OR INDUSTRY RETIRED
11. BIRTHPLACE (State or foreign country) [redacted] MARYLAND
12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME ISAAC GROLMAN
14. MOTHER'S MAIDEN NAME ESTHER [redacted] DEITCH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-3827
17. INFORMANT MRS. ROSE G. RAFFEL, ADDRESS 6509 BAYTHORNE ROAD

MEDICAL CERTIFICATION

18. 411X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO R Pulmonary Edema & Bronchopneumonia
(B) DUE TO Rheumatic Heart Disease with 12 yrs.
(C) Aortic stenosis

A. Rizzolito, M.D.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —
20A. AUTOPSY? (Yes or No) Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/5 1967 to 4/5 1967 that (I) (we) last saw the deceased alive on 4/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Robert P. Doyle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED 4/5/67
23C. PHYSICIAN'S NAME (Type) Robert P. Doyle M.D.
23D. ADDRESS Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 4/7/67
24C. NAME of CEMETERY or CREMATORY (ANSHE EMUNAH) - AITZ CHAIM
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT. APR 11 1967
25B. NAME OF REGISTRAR [illegible]
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., ADDRESS 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

574 16

BIRTH NO. 67 3541

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3541

1. NAME OF DECEASED (Type or Print): SILBERSCHLAG, CHARLES

2. DATE AND HOUR OF DEATH: 4-7-67 | 4.30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 130 Slade Ave. #8

5. SEX: M
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-4-07
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10B. KIND OF BUSINESS OR INDUSTRY: SHOES
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JULIUS SILBERSCHLAG
14. MOTHER'S MAIDEN NAME: GUSSIE SEAMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-32-1894
17. INFORMANT: MRS. SOPHIE SILBERSCHLAG
ADDRESS: 130 SLADE AVENUE

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.1 + 260X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary edema. — 2 hours
DUE TO
(B) Acute myocardial infarction — 5 days
DUE TO
(C) Arteriosclerotic cardiovascular disease.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Diabetes mellitus

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-3-1967 to 4-7-1967, that (I) (we) last saw the deceased alive on 4-7-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-7-67
23C. PHYSICIAN'S NAME (Type): Francisco Sainz M.D.
23D. ADDRESS: Sinai Hospital H.O.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/9/67
24C. NAME OF CEMETERY or CREMATORY: MOGAN ABRAHAM
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.
ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

1967 0 0 3 5 4 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-431

BIRTH NO. 67 3542

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3542

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LOUIS GOLDBERG

2. DATE AND HOUR OF DEATH: 4/7/67 1115A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 7912 LIBERTY RD. 21207

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 1/6/91
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAILOR
10B. KIND OF BUSINESS OR INDUSTRY: CLOTHING
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? ? USA
13. FATHER'S NAME: HESSEL GOLDBERG
14. MOTHER'S MAIDEN NAME: ROSE COPLIN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: CHART, HOSPITAL
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 595X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: ABOUT 3 MO.
DUE TO
(B) RENAL DISEASE — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLS BLAT -

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/4 1967 to 4/7 1967, that (I) (we) last saw the deceased alive on 4/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sheldon Frank M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/7/67
23C. PHYSICIAN'S NAME (Type): SHELDON FRANK M.D.
23D. ADDRESS: SINAI HOSPITAL OF BALTO

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/9/67
24C. NAME of CEMETERY or CREMATORY: LUBOWITZ NUSI ARI (NEW)
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.
ADDRESS: 6010 REIST.

VS 150-REV. 1964

67 003550

S-165

BIRTH NO. 67 3543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3543

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REBECCA SAFFRON

2. DATE AND HOUR OF DEATH: APRIL 8, 1967 — 8:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BELVEDERE NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-12
D. STREET ADDRESS (If rural, give location): 3834 COTTAGE AVENUE

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: APRIL 1, 1893
9. AGE (In years last birthday): 74
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: BENJAMIN EISENSTEIN
14. MOTHER'S MAIDEN NAME: IDA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: MRS. HENRY W. BERNSTEIN
ADDRESS: 3333 NORTHMONT RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

I 334X

(A) Pneumonia — 3 days
DUE TO
(B) Cerebral arteriosclerosis — 20 years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Jan 1967 to April 8 1967, that (I) (we) last saw the deceased alive on April 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert Levy M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/8/67
23C. PHYSICIAN'S NAME (Type): DR. ROBERT I. LEVY M.D.
23D. ADDRESS: MEDICAL ARTS BLDG.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/9/67
24C. NAME of CEMETERY or CREMATORY: OHEL YAKOV
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.
ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

0 3 5 5 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3544 Registered No. 67 3544

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Roll, Sarah

2. DATE AND HOUR OF DEATH: April 8 1967 | 4 55 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Hebrew Home and Infirmary -

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): Levindale Aged Home

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow		94		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Russia	USA

13. FATHER'S NAME: ? Kemper

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: Mrs. Bessie Kerber ADDRESS: 3433 Park Heights Ave.

MEDICAL CERTIFICATION

18. I 493X 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia, severe — 2 weeks

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD - Diabetes

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 26 1965 to April 8 1967, that (I) (we) last saw the deceased alive on April 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Ruth Willner M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 8 1967

23C. PHYSICIAN'S NAME (Type): Ruth Willner M.D.

23D. ADDRESS: Levindale, Hebrew Home and Infirmary

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/9/1967	Hebrew Young Mens	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. ADDRESS: 6010 Reisterstown Road

VS 150-REV. 1/1/65

93 / 67 0 3 5 5 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-00d

BIRTH NO. 67 3545

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3545

1. NAME OF DECEASED (Type or Print): Chauncey D. Lowe

2. DATE AND HOUR OF DEATH: April 8 1967 8:52 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Harford ~~BALTIMORE~~

C. CITY OR TOWN (If outside city limits, write RURAL and give township): White Hall Rural 53-00

D. STREET ADDRESS (If rural, give location): Route # 2

5. SEX: Male

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 6-7-94

9. AGE (In years last birthday): 72

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Own ~~Farm~~

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Laban Lowe

14. MOTHER'S MAIDEN NAME: Margaret Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-34-5998

17. INFORMANT: Mrs. Lorraine L. Lowe, White Hall, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — March 28 1967

DUE TO

(B) Arteriosclerotic Coronary Artery Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-28 — 1967 to 4-8 — 1967, that (I) (we) last saw the deceased alive on 4-8 — 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Miriam R. Cohen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-8-67

23C. PHYSICIAN'S NAME (Type): MIRIAM R. COHEN M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/11/67

24C. NAME of CEMETERY or CREMATORY: Friends Cemetery

24D. LOCATION (City, town, or county) (State): Fawn Grove, York Co., Penna.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Kenneth W. Chubb

ADDRESS: Stewartstown, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-06317 67 3546

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3546

1. NAME OF DECEASED (Type or Print): PRICE, Baby Boy Robert Jr.

2. DATE AND HOUR OF DEATH: April 8 1967 7:40 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Harford

C. CITY OR TOWN (If outside city limits, write RURAL and give township): STREET, MARYLAND. 62-00

D. STREET ADDRESS (If rural, give location):

5. SEX: M

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: 3/31/67

9. AGE (In years last birthday): 0

If Under 1 Yr. Months: 0 Days: 7 If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: —

13. FATHER'S NAME: Robert Price

14. MOTHER'S MAIDEN NAME: HELEN- Thompson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: R.R.Price, Street, Md.

ADDRESS:

MEDICAL CERTIFICATION

1B. 763.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO: CARDIO-RESPIRATORY ARREST

(B) DUE TO: Septis

(C): Pneumonia, Rural Stream

INTERVAL BETWEEN ONSET AND DEATH: ~~5~~ Days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): ? Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that ~~I~~ (this hospital) attended the deceased from MARCH 31 1967 to April 8 1967, that ~~I~~ (we) last saw the deceased alive on April 8 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Danny Givelas M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: April 8 67

23C. PHYSICIAN'S NAME (Type): DR. DANNY GIVELAS DANNY GIVELAS M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/10/67

24C. NAME of CEMETERY or CREMATORY: Sharon Bapt. Cem. ~~Susquehanna Mem.~~

24D. LOCATION (City, town, or county) (State): Forest Hill, Harford Co. ~~Fork Pa., Fork Co.~~ Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: R. L. E. Farber M.D.

25C. FUNERAL DIRECTOR: Kenneth W. Cochran

ADDRESS: Stewartstown, Pa.

VS 150-REV. 1/1/65

3553

48-99-24 DH

B-415

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-06281 67 3547

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3547 4

1. NAME OF DECEASED (Type or Print): Blevins, Baby Girl, ~~Ila Rae~~ Blevins, baby girl, Ila

2. DATE AND HOUR OF DEATH: 4/1/67 - 1:19 pm | 1:19 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00

D. STREET ADDRESS (If rural, give location): 109 Compass Road #21221

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married

8. DATE OF BIRTH: 4/1/67

9. AGE (In years last birthday): If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours: 2 | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Md. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lacy

14. MOTHER'S MAIDEN NAME: Ila M Rush

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: BCH: Medical records ADDRESS: 4940 Eastern Avenue Baltimore, Md. #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1 1967 to 4/1 1967, that (I) (we) last saw the deceased alive on 4/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Julio Zavala M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/1/67

23C. PHYSICIAN'S NAME (Type): Julio Zavala M.D.

23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 4-5-67

24C. NAME of CEMETERY or CREMATORY: Baltimore City Hospitals

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Alex E. Sakaguchi

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL ADDRESS

VS 150-REV. 1/1/65

48-97-80 DH 1 J-560 67-06091 67 3548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3548

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Boy Joyner, ~~Lenora~~

2. DATE AND HOUR OF DEATH: 3/31/67 12:14 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-38

D. STREET ADDRESS (If rural, give location): 3407 Bateman Avenue #21216

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married

8. DATE OF BIRTH: 3/30/67

9. AGE (In years last birthday): If Under 1 Yr. Months: 0 Days: 1 If Under 24 Hrs. Hours: 7 Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): baby

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: not given

14. MOTHER'S MAIDEN NAME: Lenora Joyner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: BCH ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland #21224

RECORDS:

MEDICAL CERTIFICATION

1B. 7235 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory distress syndrome — 31 hrs

DUE TO

(B) Prematurity — 31 hrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30 19 67 to 3/31 19 67 that (I) (we) last saw the deceased alive on 3/31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A M Overbach M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 3/31/67

23C. PHYSICIAN'S NAME (Type): A M Overbach M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 4-5-67

24C. NAME of CEMETERY or CREMATORY: Baltimore City Hospitals

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Farber

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL

ADDRESS

VS 150-REV. 1/1/65

67 06091 3556

D 242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3549 Registered No. 67 3549

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT DOUGLASS

2. DATE AND HOUR OF DEATH: 4-10-67 | 11:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Glen Burnie 52-02
D. STREET ADDRESS (If rural, give location): 5 COUNTRY CLUB DRIVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	10-5-27	39		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
REPAIRMAN	F.A. Senger, Co.	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Edward Douglass

14. MOTHER'S MAIDEN NAME: Mamie Ramsey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Mrs. Gloria F. Douglass (wife) ADDRESS: Same As #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-10- 1967 to 11:30AM, 4-10 1967, that (I) (we) last saw the deceased alive on ..... 19..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: K-M Anandaiah. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): K.M. ANANDAIAH. M.D.

23D. ADDRESS: Church home & hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 14/67

24C. NAME of CEMETERY or CREMATORY: Glen Haven Mem. Pk.

24D. LOCATION (City, town, or county) (State): Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Lackey M.D.

25C. FUNERAL DIRECTOR: R.V. Singleton

ADDRESS: Singleton Funeral Home Glen Burnie, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3550 Registered No. 67 3550

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES LANG - SR.

2. DATE AND HOUR OF DEATH: 4-9-67 6:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Anne Arundel

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE 52-00

D. STREET ADDRESS (If rural, give location): 319 SHIPLEY AVE.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: July 5-'21

9. AGE (In years last birthday): 45

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICAL WORKER.

10B. KIND OF BUSINESS OR INDUSTRY: ELECTRICAL INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES A. LANG

14. MOTHER'S MAIDEN NAME: MYRTLE SMITH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): 1942-5

16. SOCIAL SECURITY NO.: 217-14-0081

17. INFORMANT: Mrs. Rita S. Lang (wife) ADDRESS: Same As #4

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 289.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: JAN 1966

DUE TO

(B) ASPIRATION PNEUMONIA

DUE TO

(C) HISTIOCYTOSIS X — APRIL 1967

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1st 1967 to April 9th 1967, that (I) (we) last saw the deceased alive on April 9th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John C. Whelton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-9-67

23C. PHYSICIAN'S NAME (Type): JOHN C. WHELTON M.D.

23D. ADDRESS: 1620 McELDERRY ST. BALTIMORE 21205

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 13/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county): Baltimore (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: R. V. Singleton

ADDRESS: Singleton Funeral Home Glen Burnie, Md.

VS 150-REV. 1/1/65

67 3550

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-625

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3551 Registered No. 67 3551

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dorothy Perkinson

2. DATE AND HOUR OF DEATH: 5:35 Am 4/8/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Severn 52-00
D. STREET ADDRESS (If rural, give location): Box 122 Rt 3

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9/8/1914
9. AGE (In years last birthday): 52
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurses Aid
10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Hosp.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: James B. Grenagle
14. MOTHER'S MAIDEN NAME: Mary Hewitt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-28-6349
17. INFORMANT: Mr. William B. Perkinson (husband) ADDRESS: Same As #4

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 1250 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Septicemia
DUE TO
(B) Bil. Pleural effusion
DUE TO
(C) Papillary adenocarcinoma of ovary c̄ metastases

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 3/31/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Excised Pelvic Mass
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/29 1967 to 4/8 1967, that (I) (we) last saw the deceased alive on 4/8 @ 5:35 Am 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Roosevelt Taylor, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/8/67
23C. PHYSICIAN'S NAME (Type): ROOSEVELT TAYLOR Jr. M.D.
23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 11, 1967
24C. NAME of CEMETERY or CREMATORY: Glen Haven Memorial Park
24D. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Quincy E. Tarlow M.D.
25C. FUNERAL DIRECTOR: R. V. Singleton
ADDRESS: Singleton Funeral Home Glen Burnie, Md.

VS 150-REV. 1/1/65

0 0 0 3 5 5 9

S-363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3552 Registered No. 67 3552

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SARAH M. STEWART

2. DATE AND HOUR OF DEATH: APRIL 10, 1967, 12:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 15-47

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 3204 Clifton Avenue

D. STREET ADDRESS (If rural, give location): ~~FAYETTE & CALHOUN STS~~

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: OCT. 1, 1879

9. AGE (In years last birthday): 87

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. ~~[illegible]~~

10B. KIND OF BUSINESS OR INDUSTRY: Secretary / Manufacturing

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~[illegible]~~ Alfred J. Morris

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): ~~[illegible]~~

16. SOCIAL SECURITY NO.: 217-18-5837

17. INFORMANT: Miss Edith Long (Niece)

ADDRESS: #508 Delmar Ave. Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

(B) Cerebral infarction

DUE TO

(C) Arteriosclerosis, cerebral

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 19__ to April 10 1967, that (I) (we) last saw the deceased alive on April 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Josefina T. Naraval M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: April 10, 1967

23C. PHYSICIAN'S NAME (Type): JOSEFINA T. NARAVAL M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 13, 1967

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State): Brooklyn, RFD, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: P K Singleton

ADDRESS: Singleton Funeral Home Glen Burnie, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-600

BIRTH NO. 67 3553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3553

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph B Thayer

2. DATE AND HOUR OF DEATH: Apr 10,1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3611 St Margarets St Baltimore,Md 21225

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-05
D. STREET ADDRESS (If rural, give location): 3611 St Margarets St

5. SEX: Male
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 7,1891
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Thayer
14. MOTHER'S MAIDEN NAME: Unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family
ADDRESS: Same

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonitis — 2 yr
DUE TO
(B) lung cancer — over 1 yr.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 13 1966 to 4.10 1967, that (I) (we) last saw the deceased alive on 4.10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Henry C Plummer M.D.
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4.11.67
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS M.D.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/67
24C. NAME of CEMETERY or CREMATORY: Glen Haven Cem
24D. LOCATION (City, town, or county) (State): Glen Burnir AA Co MD

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Falkenna
25C. FUNERAL DIRECTOR: McCully F H
ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

M-460

BIRTH NO. 67 3554

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3554

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RAY G. MILLER

2. DATE AND HOUR PRONOUNCED DEAD: April 9, 1967 12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Mercy Hospital (DOA)

3/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01

D. STREET ADDRESS (If rural, give location): 113 W. Lee Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Dec 7 1925

9. AGE (In years last birthday): 41

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl Miller

14. MOTHER'S MAIDEN NAME: Hazel Richter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Familt ADDRESS: Same

MEDICAL CERTIFICATION

18. E975X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): water

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): near seaway at Calvert and Conway Streets

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4-9-67 11:45 A.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Presumably jumped into water 22-01

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: April 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/12/67

23C. NAME of CEMETERY or CREMATORY: Rest Haven Cem

23D. LOCATION (City, town, or county) (State): Hagerstown Md

24A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: McCully F H

ADDRESS: 237 Patapsco Ave 21225

VS 151-REV. 1/1/65

N 991X 67 0 0 3 5 6 2

5-36 13

BIRTH NO. 67 3555

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3555

1. NAME OF DECEASED (Type or Print): STREIT, RUTH VIRGINIA

2. DATE AND HOUR OF DEATH: APRIL 7, 1967 | 9:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE COUNTY

C. ~~CITY OR TOWN~~ (If outside city limits, write RURAL and give township): BALTIMORE 53-D

D. STREET ADDRESS (If rural, give location): 23 FUSTING AVENUE

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11-23-92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES BROWN DEC'D

14. MOTHER'S MAIDEN NAME: VIRGINIA LEE (YEW) BROWN DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-48-0364 UNKNOWN

17. INFORMANT: CATON & WILKENS AVES. ADDRESS #21229 HOSPITAL RECORD-ST. AGNES HOSPITAL

MEDICAL CERTIFICATION

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro vascular accident

~~DUE TO~~

(B) Arteriosclerotic cardiovascular disease

~~DUE TO~~

(C) Diabetes Mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that X(I) (this hospital) attended the deceased from MARCH 29, 19 67 to APRIL 7, 19 67, that X(I) (we) last saw the deceased alive on APRIL 7, 19 67 and that in ~~(my)~~ XX (our) opinion death occurred on the date and hour and from the causes stated above. (X (We) (did) (~~did not~~) XXX view the body after death.

23A. SIGNATURE: Pablo E. Dibos M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 4-7-67

23C. PHYSICIAN'S NAME (Type): PABLO E. DIBOS M.D.

23D. ADDRESS: BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES.

24A. BURIAL CREMATION, REMOVAL (Specify): REMOVAL

24B. DATE: 4/11/1967

24C. NAME of CEMETERY or CREMATORY: MT. HEBRON HEBRON

24D. LOCATION (City, town, or county) (State): WINCHESTER, VA.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Easton Funeral Home Catons. Md. ADDRESS

VS 150-REV. 1/1/65

67 0 0 0 3 5 6 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-100

BIRTH NO. 67 3556

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3556

1. NAME OF DECEASED (Type or Print): HENRY LEVY

2. DATE AND HOUR OF DEATH: 4-8-67 8.15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 714 Silver Creek Rd. #08

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8-10-04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: U. S. Weather Bureau

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathan Levy

14. MOTHER'S MAIDEN NAME: Yetta ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-44-4764

17. INFORMANT: Mr. Harry Levy, 514 Gwynnvale Road #8

ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 4 1965 to 4/8 1967, that (I) (we) ~~last~~ saw the deceased alive on 4/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Benjamin Berdann M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/8/67

23C. PHYSICIAN'S NAME (Type): BENJAMIN BERDANN M.D.

23D. ADDRESS: Lutheran Hospital of Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/10/67

24C. NAME of CEMETERY or CREMATORY: Hebrew Young Men

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: R. E. Fahey M.D.

25C. FUNERAL DIRECTOR: SOL IEVINSON & BROS. INC.

ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-60d

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3557

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3557

1. NAME OF DECEASED (Type or Print): MOORE, ANNE N. -

2. DATE AND HOUR OF DEATH: APRIL 9, 1967 | 8:30P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE 21221
C. CITY OR TOWN (If outside city limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 900 OREMS RD. 53-00

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 07/9/20
9. AGE (In years last birthday): 46
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HARRY MURRAY
14. MOTHER'S MAIDEN NAME: MABEL MC GEE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 221 10 8703
17. INFORMANT: ST. AGNES RECORDS, WILKENS & CATON AVE. BALTO. MD.
ADDRESS: 21229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Cervix Stage IV with Uremia and Bilateral
DUE TO
(B) Hydronephrosis
DUE TO
(C) Bronchopneumonia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that XX (this hospital) attended the deceased from MARCH 13 1967 to APRIL 9 1967, that X (we) last saw the deceased alive on APRIL 9 1967 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) XXXX view the body after death.

23A. SIGNATURE: B. Robert Giangrandi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): B. ROBERT GIANGRANDI M.D.
23D. ADDRESS: ST. AGNES HOSPITAL WILKENS & CATON AVE., BALTO. MD. 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/13/67
24C. NAME of CEMETERY or CREMATORY: Gracelawn Memorial Park
24D. LOCATION (City, town, or county) (State): Wilmington, Delaware

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Falkenna
25C. FUNERAL DIRECTOR: Albert J. McCrery Jr. Wilm. Del.
ADDRESS:

VS 150-REV. 1/1/65

M-245

67-0 4063

BIRTH NO. 67 3558

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3558

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): McCALLUM, PAIGE KIRSTEN

2. DATE AND HOUR OF DEATH: APRIL 9, 1967 | 5:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: CARROLL
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WEST MINSTER 56-27
D. STREET ADDRESS (If rural, give location): 243 SMITH AVE.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 2/21/67
9. AGE (In years last birthday): If Under 1 Yr. Months: 1 Days: 19 | If Under 24 Hrs. Hours: | Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES McCALLUM
14. MOTHER'S MAIDEN NAME: CYNTHIA FROLEN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: HOSPITAL RECORDS — ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B 7543

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONG. HEART DIS.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from APRIL 4 19 67 to APRIL 9 19 67, that ☒ (we) last saw the deceased alive on APRIL 9 19 67 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alfred Rosenstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-9-67
23C. PHYSICIAN'S NAME (Type): ALFRED ROSENSTEIN M.D.
23D. ADDRESS: UNIVERSITY HOSP BALTO. MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/11/67
24C. NAME of CEMETERY or CREMATORY: Mestow Brand Cemetery
24D. LOCATION (City, town, or county) (State): Rural, Westminster Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Foxberg M.D.
25C. FUNERAL DIRECTOR: J. E. Myers Jr.
ADDRESS: Westminster, Md.

VS 150-REV. 1/1/65

H-250

67 3559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3559

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MRS. M. LORETTA HYSAN

2. DATE AND HOUR OF DEATH: APRIL 7, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSPITAL BALTIMORE, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-01

D. STREET ADDRESS (If rural, give location): 225 WENDOVER ROAD

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: JAN 17, 1897

9. AGE (In years last birthday): 70

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES DAVIS

14. MOTHER'S MAIDEN NAME: ANNA C. G. MURPHY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MR. W. B. HYSAN, JR. ADDRESS: 225 WENDOVER RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Acute Pulmonary Embolism

(B) DUE TO: Congestive Heart Failure

(C): Arteriosclerotic Cardiovascular Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-12 1967 to 4-7 1967, that (I) (~~we~~) last saw the deceased alive on 4-7 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Michael A. Ellis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-7-67

23C. PHYSICIAN'S NAME (Type): Michael A. Ellis M.D.

23D. ADDRESS: Mercy Hospital Balto Md.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/11/67

24C. NAME of CEMETERY or CREMATORY: NEW CATHEDRAL

24D. LOCATION (City, town, or county) (State): BALTIMORE MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: H. W. MEARS & SON ADDRESS: 805 N. CALVERT ST.

VS 150-REV. 1/1/65

67 0 0 3 5 6 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-300

BIRTH NO. 67 3560

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3560

1. NAME OF DECEASED (Type or Print): Maude D. Lloyd

2. DATE AND HOUR OF DEATH: 4-567 | 11:25 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Keswick Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07

D. STREET ADDRESS (If rural, give location): 700 W. 40th Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 11-15-85

9. AGE (In years last birthday): 81

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Vogts

14. MOTHER'S MAIDEN NAME: Annie Crue

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 215-07-0825

17. INFORMANT: Medical Records-Keswick

ADDRESS:

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Arteriosclerotic CVD

DUE TO w. aortic aneurysm

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: ? yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rheumatoid Arthritis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 1963 to 5 April 1967, that (I) (we) last saw the deceased alive on 5 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold P. Biehl M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 5 April 67

23C. PHYSICIAN'S NAME (Type): Harold P. Biehl M.D.

23D. ADDRESS: 700 W. 40th Street

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: APL. 8, 1967

24C. NAME of CEMETERY or CREMATORY: GRACE-FALLS RD. CEM.

24D. LOCATION (City, town, or county) (State): Cockeysville, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: John Burns' Sons, Towson, Md.

ADDRESS:

VS 150-REV. 1/1/65

67 0 0 3 5 6 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3561 Registered No. 67 3561

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Casper Paul Haller

2. DATE AND HOUR OF DEATH: 4/8 10:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: Baltimore County C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson 53-00 D. STREET ADDRESS (If rural, give location): 507 W. Chesapeake Avenue

5. SEX: M 6. RACE: Caucasian 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED 8. DATE OF BIRTH: 7/5/98 9. AGE (In years last birthday): 68 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHEMICAL ENG.-RET. 10B. KIND OF BUSINESS OR INDUSTRY: STANDARD OIL CO. 11. BIRTHPLACE (State or foreign country): New York 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Casper Haller 14. MOTHER'S MAIDEN NAME: ~~Casper~~ Florence Allen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT: Family Records ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Acute Hemorrhagic Pancreatitis — 2 Weeks

(B) DUE TO: Retroperitoneal Abscess

(C): M. Jimenez

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4/2/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Intestinal Obstruction 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30 1967 to 4/8 1967, that (I) (we) last saw the deceased alive on 4/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles H. Classen Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4/8/67

23C. PHYSICIAN'S NAME (Type): CHARLES H. CLASSEN, JR. M.D. 23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: Apl. 10, 1967 24C. NAME of CEMETERY or CREMATORY: DULANEY VALLEY MEMORIAL 24D. LOCATION (City, town, or county) (State): COCKEYSVILLE, MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: John Burns' Sons, Towson, Md. ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3562 Registered No. 67 3562

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STEWART, DAVID

2. DATE AND HOUR OF DEATH: 4/6/67 1:15 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 402
D. STREET ADDRESS (If rural, give location): m 666 West Saratoga Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 1/16/19
9. AGE (In years last birthday): 48
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): L
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Stewart
14. MOTHER'S MAIDEN NAME: Sarah

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Genaeva Stewart
ADDRESS: 1610 Warwick

MEDICAL CERTIFICATION

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 1 hour
DUE TO
(B) Hypertension — 5 yrs
DUE TO
(C) Diabetes — 5 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 4/4 19 67 to 4/6 19 67, that (I) (we) last saw the deceased alive on 4/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sherrard Hayes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/6/67
23C. PHYSICIAN'S NAME (Type): Sherrard Hayes M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-12-67
24C. NAME of CEMETERY or CREMATORY: Mount Auburn
24D. LOCATION (City, town, or county) (State): Baltimore-City

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: Isaiah L. Brown and Son
ADDRESS: 108 W. Montgomery Street

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

36 32 86 RS
STEWART, DAVID 5
5-3167

B-624

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3563 Registered No. 67 3563

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN B. BORSELLA

2. DATE AND HOUR PRONOUNCED DEAD: April 10, 1967 4:47 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): LUTHERAN HOSPITAL 46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-02
D. STREET ADDRESS (If rural, give location): 5507 Gwynn Oak Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-3-1901
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STONE MASON
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~STONE~~ FRANK BORSELLA
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes WWI
16. SOCIAL SECURITY NO.: 218-05-1193
17. INFORMANT: MARY ELLEN BORSELLA
ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 4-11-67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 4-14-67
23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md

24A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 4600 Liberty Heights Ave

VS 151-REV. 1/1/65

1967 000 3571

U-3201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3564 Registered No. 67 3564

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph BYRON UTZ

2. DATE AND HOUR OF DEATH: 4-10-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Belvedere - House In The Pines

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 53-00
D. STREET ADDRESS (If rural, give location): 3616 Oak Ave #07

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower
8. DATE OF BIRTH: Aug 8, 1877
9. AGE (In years last birthday): 89
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railway Postal Clerk
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Beaver Creek, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph H Utz
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-10-1803
17. INFORMANT: Elaine Peppler - Same ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Parkinson disease
DUE TO: Cerebral arteriosclerosis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C) Pt seen at patient of Dr. Marvin Davis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 10 1967 to April 10 1967, that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R Perez-Mera M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-10-67
23C. PHYSICIAN'S NAME (Type): R. PEREZ-MERA M.D.
23D. ADDRESS: 7306 Liberty Rd Balto Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 4600 Liberty Heights Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-416

BIRTH NO. 67 3565

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3565

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN H. L. CLIPPER, JR

2. DATE AND HOUR PRONOUNCED DEAD: April 11, 1967 4:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1537 S. Charles Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE -
8. DATE OF BIRTH: FEB 11 - 1895
9. AGE (In years last birthday): 72
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Ship Woodcarver
10B. KIND OF BUSINESS OR INDUSTRY: U.S.C.G. Shipyard
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. L. Clipper, SR.
14. MOTHER'S MAIDEN NAME: Annie C. Knowlman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-09-0146
17. INFORMANT: Mrs. Margaret E. Oftein
ADDRESS: 417 East Lynn Ave 21223

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis
DUE TO
(B) Perforation of Rectum.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic Cardiovascular Disease
Pulmonary Emphysema.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): South Baltimore General Hospital 24-03

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 10 (Year) '67 (Hour) A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Perforation of rectum during diagnostic barium enema.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial -
23B. DATE: Apr. 14-1967
23C. NAME of CEMETERY or CREMATORY: Balto Cemetery
23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
24B. NAME OF REGISTRAR: Robert E. Farkey M.D.
24C. FUNERAL DIRECTOR: CURTIS E. EVANS
ADDRESS: 1400 S. Charles St. 21230

VS 151-REV. 1/1/65

N997X 967000 3573

W-321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3566 Registered No. 67 3566

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES WATTS

2. DATE AND HOUR OF DEATH: APRIL 9-1967 11.10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1226 W. LAFAYETTE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-01
D. STREET ADDRESS (If rural, give location): 1226 W. LAFAYETTE AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	COLORED	SEPARATED	9-30-13	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): ELEVATOR OPERATOR
10B. KIND OF BUSINESS OR INDUSTRY: HOTEL
11. BIRTHPLACE (State or foreign country): St Mary's Co. MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES WATTS SR.
14. MOTHER'S MAIDEN NAME: GERTRUDE WASHINGTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-09-6485
17. INFORMANT: LILLIE ROLLINS ADDRESS: 1226 W LAFAYETTE

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARCINOMATOSIS
DUE TO
(B) CARCINOMA of Esophagus — 1½ years
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-10 1963 to 4-9 1967, that (I) (we) last saw the deceased alive on 4-8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel R. Owings, Jr., M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-10-67
23C. PHYSICIAN'S NAME (Type): SAMUEL R. OWINGS, JR., M.D.
23D. ADDRESS: 909-11 N. CAREY ST. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/12/67
24C. NAME of CEMETERY or CREMATORY: McCleary
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR: Maurice R. Hayes ADDRESS: 638 N Gilmor

VS 150-REV. 1/1/65

1967003579

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452

BIRTH NO. 67 3567

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3567

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WILLIAMS, CHARLES

2. DATE AND HOUR OF DEATH: 4 | 11 | 1967 3-20AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-07

D. STREET ADDRESS (If rural, give location): 420 Edgewood St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	C	WIDOWED	3-1-97	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S. Car.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 705122147

17. INFORMANT: Cora Williams ADDRESS: 420 Edgewood St

MEDICAL CERTIFICATION

1B. 445X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PULMONARY OEDEMA

DUE TO

(B) ARTERIO SCLEROTIC HYPER

DUE TO

(C) TENSIVE CARDIO VASCULAR DISEASE

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4 | 10 | 1967 to 4 | 11 | 1967, that (I) (we) last saw the deceased alive on 4 | 11 | 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-14-67	Mt. Auburn Cem.	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

1967 0 0 3 5 6 7

S-120

BIRTH NO. 67 3568

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3568

1. NAME OF DECEASED (Type or Print): Anna Sobus

2. DATE AND HOUR OF DEATH: April 11, 1967 | 6:00 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 15 S. Castle Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 15 S. Castle Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	Aug. 20, 1882	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jacob Szafarz

14. MOTHER'S MAIDEN NAME: Katherine Oleskowicz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): — — — — —

16. SOCIAL SECURITY NO.: 214-56-9256

17. INFORMANT: Miss Angeline Sobus — ADDRESS: 15 S. Castle St. #21231

MEDICAL CERTIFICATION

1B. 420.0

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C) Generalized Arteriosclerosis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1950 19 to 4/11/67 19, that (I) (we) last saw the deceased alive on 4/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis Vogel Jr M.D.

Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): Louis Vogel, Jr., M.D. M.D.

23D. ADDRESS: 2601 E. Monument St., Baltimore, Md. 21205

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/14/67

24C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: George A. Weber — ADDRESS: 705 S. Ann St. #21231

VS 150-REV. 1/1/65

0 7 0 0 3 5 7 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3569 Registered No. 67 3569

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHNSON, HERBERT

2. DATE AND HOUR OF DEATH: APRIL 8, 1967 7:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 863 VINE ST.

36 18-01

5. SEX: M
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 5-20-05
9. AGE (In years last birthday): 60 61
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): RICHMOND, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHNSON, JAMES
14. MOTHER'S MAIDEN NAME: VIRGIL JOHNSON
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HERBERT LOWE
ADDRESS: 1811 E. FEDERAL ST

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH
(A) Dehydration DUE TO
(B) pneumonitis DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: from ? to April 8, 67, 7:25 PM

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: CHRONIC ALCOHOLISM

CERTIFICATION APPROVED BY: M.D. CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 8 19 67 to April 8 19 67, that (I) (we) last saw the deceased alive on April 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Bae Ha, M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: April 8, 67
23C. PHYSICIAN'S NAME (Type): M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-16-67
24C. NAME of CEMETERY or CREMATORY: PRIVATE
24D. LOCATION (City, town, or county) (State): MINERAL VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: J. Knight
ADDRESS: 1639 N. BROADWAY

VS 150-REV. 1/1/65

V-250

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3570

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Jackson, Thelma C

2. DATE AND HOUR OF DEATH: 4-9-67. 11:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2707 East Federal Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2707 E. Federal St.

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1-16-20
9. AGE (In years last birthday): 47
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richmond Virginia
12. CITIZEN OF WHAT COUNTRY? America United States of

13. FATHER'S NAME: Robert Rice
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-12-8777
17. INFORMANT: Howard Jackson — ADDRESS: 2707 E. Federal St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 170X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Breast — 10 Months

DUE TO

(B) with Metastasis

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: 1-19-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CA of Breast
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~the hospital~~) attended the deceased from Jan. 9 19 67 to April 9, 19 67, that (I) (we) last saw the deceased alive on April 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 11, 1967
23C. PHYSICIAN'S NAME (Type): Ernest O. Brown, M. D.
23D. ADDRESS: 3414 Duvall Avenue, Baltimore, Maryland 21216

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4.13.67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemet
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: Lindsay H Carroll
ADDRESS: Balto Md

VS 150-REV. 1/1/65

K-500

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3571 Registered No. 67 3571

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES W. KEENE

2. DATE AND HOUR OF DEATH: 4-11-67 7:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LITTLE SISTERS OF THE POOR, 1200 VALLEY STREET, BALTIMORE, MARYLAND 21202

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1200 VALLEY STREET

10-01

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 7-4-1870
9. AGE (In years last birthday): 96
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN KEENE
14. MOTHER'S MAIDEN NAME: NANCY MOORE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-54-3270J1
17. INFORMANT: LITTLE SISTERS OF THE POOR, 1200 VALLEY STREET — ADDRESS: BALTIMORE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema
DUE TO
(B) Chronic C.S. heart
DUE TO
(C) failure
Generalized arteriosclerosis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1966 to April 11 1967, that (I) (we) last saw the deceased alive on April 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4.12.67
23C. PHYSICIAN'S NAME (Type): STANLEY ANKUDAS M.D.
23D. ADDRESS: 1101 Maiden Choice La Balto

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Philip Herwig Sons Orleans st
ADDRESS: 2024

VS 150-REV. 1/1/65

H-416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3572 Registered No. 67 3572

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): George J. Helfer

2. DATE AND HOUR OF DEATH: April 8/67 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2828 Lake Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 2828 Lake Ave

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 801

D. STREET ADDRESS (If rural, give location): 2828 Lake Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	widowed	10/5/1894	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Helfer

14. MOTHER'S MAIDEN NAME: Fannie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-4426A

17. INFORMANT: Norman A. Cuneo (Nephew) ADDRESS 7606 Old Harford Rd.

MEDICAL CERTIFICATION

1B. 4.20.0 1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arterio-sclerotic heart disease.

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 1962 to 4/8 1967, that (I) (~~we~~) last saw the deceased alive on 4/6 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Joseph R. Liberto M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): JOSEPH R. LIBERTO M.D.

23D. ADDRESS: 3508 BANT ST. Baltimore Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/11/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Falkenan

25C. FUNERAL DIRECTOR: Philip Herwig Sons

ADDRESS 2024 Orleans St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1765

0 7 0 3 5 8 6

SAB-38-85-93 16-526 67 3573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3573

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Barbara Ganzermiller

2. DATE AND HOUR OF DEATH: 4/6/67 8:45 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

26-36

D. STREET ADDRESS (If rural, give location): 6314 Cardiff avenue 21224

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3-22-43

9. AGE (In years last birthday): 24

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward H. Choate

14. MOTHER'S MAIDEN NAME: Virginia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-40-9053

17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 345-X 1-260X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sepsis — 2 weeks

DUE TO

(B) Multiple Sclerosis — 6 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 8 yrs.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/28 19 66 to 4/6 19 67, that (I) (we) last saw the deceased alive on 4/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William A. Emerson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/6/67

23C. PHYSICIAN'S NAME (Type): William A. Emerson M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/8/67

24C. NAME of CEMETERY or CREMATORY: Bel Air Mem. Park

24D. LOCATION (City, town, or county) (State): Bel Air Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: Robert E. Fogle M.D.

25C. FUNERAL DIRECTOR: Philip Herwig Sons

ADDRESS: 2024 Orleans St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3574

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 772 67 3574

1. NAME OF DECEASED (Type or Print): Prezzie Prezie, JOHNSON

2. DATE AND HOUR OF DEATH: 4-9-67 6:10 PM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BOLTON HILL NURSING CENTER

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-08
D. STREET ADDRESS (If rural, give location): 2308 GARRETT AVE.

5. SEX: F
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 4-2-86
9. AGE (In years last birthday): 81
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM SMITH
14. MOTHER'S MAIDEN NAME: MAGGIE
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Evelyn Jordon
ADDRESS: 804 McDought St.

MEDICAL CERTIFICATION

18. 443 X I

CAUSE OF DEATH — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Cerebral Vascular accident	10 days
DUE TO (B)	Hypertension C V disease	years
DUE TO (C)	aortic insufficiency	years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1/67 19 to 4/9 1967, that (I) (we) last saw the deceased alive on 4/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allan H. Macht M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/9/67
23C. PHYSICIAN'S NAME (Type): ALLAN H. MACHT M.D.
23D. ADDRESS: 2E READ ST. 21202

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Ralph E. Fulbright
25C. FUNERAL DIRECTOR: MARSHALL W. JONES
ADDRESS: 1735 Harford Ave.

3562

VS 150-REV. 1/1/65

F-607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3575 Registered No. 67 3575

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CARL OTTE FREY

2. DATE AND HOUR OF DEATH: APRIL 12, 1967 | 2:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4139 HAQUE AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 23-04

D. STREET ADDRESS (If rural, give location): 4139 HAQUE AVE

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	White	MARRIED	APRIL 5 1907	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SUPERVISOR	TRANSIT CO.	MARYLAND	U.S.A.

13. FATHER'S NAME: ARTHUR FREY

14. MOTHER'S MAIDEN NAME: LENA OTTO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	1923 to 1927	213-10-2778	K. LOUISE FREY	4139 HAQUE AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	CORONARY OCCLUSION	20 mm
DUE TO (B)	ARTERIOSCLEROTIC HEART DISEASE with Hypertension & cong. failure	7 yrs
DUE TO (C)		

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Group

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb ~~4~~ 1, 1963 to April 12 1967, that (I) (we) last saw the deceased alive on April 4 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: R H Spitzberg MD M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 12, 67

23C. PHYSICIAN'S NAME (Type): RANDOLPH H. SPITZBERG M.D.

23D. ADDRESS: 3384 W PRATT ST. BALTIMORE MD 21201

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4-14-67	BALTIMORE NATIONAL	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 12 1967	[illegible]	GEO. L. SCHWAB FUNERAL HOME / Francis H. Miller	2101 Frederick Ave

VS 150-REV. 1/1/65

3583

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3576 Registered No. 67 3576

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anthony M. Sansoni

2. DATE AND HOUR OF DEATH: April 10, 1967 | 10:28 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 602
D. STREET ADDRESS (If rural, give location): 2442 E. Fayette Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8/15/1899
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer
10B. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown Sansoni
14. MOTHER'S MAIDEN NAME: Catherine Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-22-8534A
17. INFORMANT: Mrs. Catherine L. Sansoni ADDRESS 2442 E. Fayette St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Pulmonary Hemorrhage — 1 hr.
DUE TO
(B) Carcinoma of the Lung — 8 mo.
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-17 1966 to 4/10 1967, that (I) (we) last saw the deceased alive on 4/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Richards M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/11/67
23C. PHYSICIAN'S NAME (Type): George J. Richards, Jr. M.D.
23D. ADDRESS: Greater Balto. Medical Center, Baltimore, Md 21204

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/'67
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

967 00 3584

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

56 82 24 26-230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3577 Registered No. 67 3577

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH E. WEISHEIT

2. DATE AND HOUR OF DEATH: 4/10/67 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 14-01
D. STREET ADDRESS (If rural, give location): 1721 PARK AVE.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6-30-93
9. AGE (In years last birthday): 73
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10B. KIND OF BUSINESS OR INDUSTRY: Legal
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: FREDERICK WEISHEIT
14. MOTHER'S MAIDEN NAME: MATHILDA GUY
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-38-6260
17. INFORMANT: Alice Ingreet B. Weisheit ADDRESS: (Above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage — 4 days
DUE TO
(B) ASCVD
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic Bronchitis & Emphysema

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/6/67 19 to 4/10/67 19, that (I) (we) last saw the deceased alive on 4/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Guy R. Newell M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): GUY R. NEWELL M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

3585

T-5201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3578 Registered No. 67 3578

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ida E. Thomas

2. DATE AND HOUR OF DEATH: April 11, 1967 | 5:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Long Green Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 3601 Greenway

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	Aug. 6, 1884	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Somerset Co., Md.	U.S.A.

13. FATHER'S NAME: Levin Theodore Horner

14. MOTHER'S MAIDEN NAME: Julia E. Kelly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-40-6408

17. INFORMANT: F2 Miss. Kathleen Kennedy ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 1551 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of Gall Bladder — 1 yr
DUE TO
(B) Carcinomatosis — 6 mos
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 8-9-1962 to 4-11-1967, that (I) (~~we~~) last saw the deceased alive on 4-10-1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death. 5:45 A.M.

23A. SIGNATURE: Robert H. Siver M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): Robert H. Siver M.D.

23D. ADDRESS: 3105 N. Charles St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/13/1967

24C. NAME of CEMETERY or CREMATORY: Deal Island

24D. LOCATION (City, town, or county) (State): Deal Island Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto. 12, Md.

0 3 5 8 6

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1631

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3579

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3579

1. NAME OF DECEASED (Type or Print): ROBERTS, MRS. CATHERINE

2. DATE AND HOUR OF DEATH: 4-8-67 | 11⁴⁵ A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-05
D. STREET ADDRESS (If rural, give location): 1617 St. Paul St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Fem.	White	Married	10/7/20	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Strasburg, Virginia	U.S.A.

13. FATHER'S NAME: Devers

14. MOTHER'S MAIDEN NAME: unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 230-01-0335

17. INFORMANT: Mr. Ernest Roberts ADDRESS: 1614 St. Paul

MEDICAL CERTIFICATION

18. 5841 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) LAENNEC'S Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: ? yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	—	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4-7 1967 to 4-7 1967, that (I) (~~we~~) last saw the deceased alive on 4-8 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William T. Mason M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-8-67

23C. PHYSICIAN'S NAME (Type): WILLIAM T. MASON M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/12/67

24C. NAME of CEMETERY or CREMATORY: Tomsbrook, Va.

24D. LOCATION (City, town, or county) (State): Tomsbrook, Virginia

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Joseph Bannino ADDRESS: 3587

VS 150-REV. 1/1/65

T-653

BIRTH NO. 67 3580

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3580

1. NAME OF DECEASED (Type or Print): James Pharoh Thornton

2. DATE AND HOUR OF DEATH: April 10, 1967 | 6: 25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, 3100 Wyman Park Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Frederick

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Brunswick 60-35

D. STREET ADDRESS (If rural, give location): 908 E. "D" Street

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 9/24/49

9. AGE (In years last birthday): 17

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Thornton

14. MOTHER'S MAIDEN NAME: Anna L. Sigler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-50-2815

17. INFORMANT: Records- US PHS Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. 573.3 I — 204.3

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Membranous colitis — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute lymphatic leukemia — Months

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I)/(this hospital) attended the deceased from Jan. 15 19 67 to Apr. 10 19 67, that (I)/(we) last saw the deceased alive on Apr. 10 19 67 and that in (my)/(our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael E. Pelczar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): Michael E Pelczar, SA Surgeon (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, 21211, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/13/67

24C. NAME of CEMETERY or CREMATORY: Union Cemetery

24D. LOCATION (City, town, or county) (State): Lovettsville Virginia

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Fritz Funeral Home ADDRESS: Brunswick Maryland

3580

VS 150-REV. 1/1/65

RGB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525

BIRTH NO. 67 3581

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3581

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): DOROTHY A. JOHNSON

2. DATE AND HOUR OF DEATH: 4-10-67 | 3 10 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital of Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 15 12
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21215
D. STREET ADDRESS (If rural, give location): 2902 Ulman Ave.

5. SEX: F
6. RACE: B
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 9-18-09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: 1
11. BIRTHPLACE (State or foreign country): Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Ignatius Keys
14. MOTHER'S MAIDEN NAME: Ida Handy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-40-1621
17. INFORMANT: Mrs. Evelyn Johnson
ADDRESS: 2902 Ulman Ave

MEDICAL CERTIFICATION

1B. 173.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Ovarian carcinoma with generalized abdominal metastasis —
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ____ 19 ____ to ____ 19 ____, that (I) (we) last saw the deceased alive on ____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E.B. Samson-Corvera M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-10-67
23C. PHYSICIAN'S NAME (Type): E. B. SAMSON-CORVERA M.D.
23D. ADDRESS: Sinai Hosp. of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 12 1967
25B. NAME OF REGISTRAR: Ralph E. Fabian
25C. FUNERAL DIRECTOR: Morton E. Dyett F.H.
ADDRESS: 1701 Laurens St

VS 150-REV. 1/1/65

1

P-265

BIRTH NO. 67 3582

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3582

1. NAME OF DECEASED (Type or Print): JOHN PEGRAM

2. DATE AND HOUR PRONOUNCED DEAD: April 10, 1967 10:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: JOHNS HOPKINS HOSPITAL

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

8-03

D. STREET ADDRESS (If rural, give location): 2706 E. Biddle Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-11-1909

9. AGE (In years last birthday): 57

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): DINWIDDIE, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN E. PEGRAM

14. MOTHER'S MAIDEN NAME: MARTHA EPPS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-8484

17. INFORMANT: Mrs. Daisey Pegram ADDRESS: 2706 E. Biddle St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E 902.6

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Traumatic concussion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Garage

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Garage - rear of 2700 E. Biddle St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): Found: 4 10 67 10:15 P.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Apparently fell from car

8-03

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4-11-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-15-67

23C. NAME of CEMETERY or CREMATORY: Dinwiddie Mem. Park

23D. LOCATION (City, town, or county) (State): Dinwiddie Virginia

24A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

24B. NAME OF REGISTRAR: Robert E. Farkey M.D.

24C. FUNERAL DIRECTOR: MORTON & DYETT F.H.

ADDRESS: 1701 Laurens St.

VS 151-REV. 1/1/65

N 521,267 0003590

1
S-632

BIRTH NO. 67 3583

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3583

1. NAME OF DECEASED (Type or Print): LEO F. SWARTZ

2. DATE AND HOUR PRONOUNCED DEAD: April 8, 1967 6:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-03

D. STREET ADDRESS (If rural, give location): 609 N. Eutaw Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	Separated	3-16-1900	67	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Swartz

14. MOTHER'S MAIDEN NAME: Melinda Croul

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-18-6267

17. INFORMANT: Mrs. Dorothy Corbin, 2611 Putty Hill Ave. ADDRESS: 21234

MEDICAL CERTIFICATION

18. 581.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-12-1967

23C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 12 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229

VS 151-REV. 1/1/65

1 8 7 0 0 0 3 5 9 1

SAB-49-02-93

RELEASED ON APPROVAL BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-435

BIRTH NO. 67 3584

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3584

1. NAME OF DECEASED (Type or Print): Theresa Feldman (CLARK)

2. DATE AND HOUR OF DEATH: 4-10-1967 6.30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1008 SOUTH CURLEY STREET 21224

1-01

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 8-19-1873
9. AGE (In years last birthday): 93
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FRANK
14. MOTHER'S MAIDEN NAME: THERESA
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS: BCH-4940 EASTERN AVENUE 21224 ADDRESS

MEDICAL CERTIFICATION

18. E 900.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia
DUE TO
(B) Hypostatic infection
DUE TO
(C) Fx. Rt hip -

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic pulm. emphysema & bronchitis

CERTIFICATION APPROVED BY, M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 4/7/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Rt hip
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): X
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME
21C. WHERE DID INJURY OCCUR? (If not Baltimore City, give exact location): 1008 CURLEY ST. ON FRONT STEP - GOING UP
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): 4/6/67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑
21F. HOW DID INJURY OCCUR? GOING UP FRONT STEPS

22. I certify that (I) (this hospital) attended the deceased from 4/6/67 19 to 4/10/67 19, that (I) (we) last saw the deceased alive on 4/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Hernandez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): V. HERNANDEZ M.D.
23D. ADDRESS: 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/14/67
24C. NAME of CEMETERY or CREMATORY: SACRED HEART CEM
24D. LOCATION (City, town, or county) (State): GERMANHILL RD MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Marie E. Trabowski
ADDRESS: 1000 S KENWOOD AVE

VS 150-REV. 1/1/65

N 8 2016

SAB*32-54-15 1 K-422 67 3585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3585

BIRTH NO.

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNA KULIKOWSKI

2. DATE AND HOUR OF DEATH: 4-11-67 | 9:22 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 312 South Macon Street 21224
26-07

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3-22-1887
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: Anna

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, etiology unknown — Months to Yr
DUE TO

ANTECEDENT CAUSES

(B)
DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~the hospital~~) attended the deceased from 3-14 19 67 to 4-11 19 67, that (I) (~~we~~) last saw the deceased alive on 4-10 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David J. Mishelevich
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): David J. Mishelovich M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-14-1967
24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY
24D. LOCATION (City, town, or county) (State): Norman High Rd MD

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Marie Falkowsky
ADDRESS: 1000 SKIENWOOD

VS 150-REV. 1/1/65

R-15D

BIRTH NO. 67 3586

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3586

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ROBINSON, THOMAS LEONARD

2. DATE AND HOUR OF DEATH: APRIL 8, 1967 | 12:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: D. C.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): WASHINGTON
D. STREET ADDRESS (If rural, give location): 1324 Montello Avenue, N.E.

V-48

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	NEGRO	DIVORCED	12-2-09	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER		WASHINGTON, D. C.	UNITED STATES

13. FATHER'S NAME: WILLIAM ROBINSON

14. MOTHER'S MAIDEN NAME: SARAH HARPER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	12-29-43/1-20-46	055-14-56-28	VA HOSPITAL RECORDS	3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH

181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF BLADDER — INTERVAL BETWEEN ONSET AND DEATH: ONE YEAR

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 13 1967 to APRIL 8 1967, that (I) (we) last saw the deceased alive on APRIL 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N Bayadi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: APRIL 9, 1967

23C. PHYSICIAN'S NAME (Type): N. BAYADI, M.D.

23D. ADDRESS: VA HOSPITAL, 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
	4-13-67	LINCOLN MEMORIAL CEMETERY	SUITLAND, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 13 1967	[illegible]	John T. Rhues Co.	Wash. D.C.

VS 150-REV. 1/1/65

3 5 9 1

P-32d

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3587 Registered No. 67 3587

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Thomas Dorsey Pitts

2. DATE AND HOUR OF DEATH: April 9, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 137 W. Lanvale St.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Baltimore, Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 137 W. Lanvale St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Aug. 20, 1872	94		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Racine, Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas G. Pitts

14. MOTHER'S MAIDEN NAME: Fitje Lavinia Canfield

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-46-3558

17. INFORMANT: Mrs. Edith DeC. S. Pitts ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Abdominal carcinomatosis — Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO:

(C):

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on 4-9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: RK Gundry M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-10-67

23C. PHYSICIAN'S NAME (Type): Dr. Richard K. Gundry M.D.

23D. ADDRESS: 2 W. University Pkwy. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	4-12-67	Loudon Park	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Farquhar M.D.

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc. ADDRESS: 6300 York Rd. Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3588 Registered No. 67 3588

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JENKINS, MADELINE

2. DATE AND HOUR OF DEATH: APRIL 12, 67 | 6 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: 21223
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 10 N. BRUCE ST.

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): (W)
8. DATE OF BIRTH: 8/19/1915
9. AGE (In years last birthday): 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY: PVT FAMILY
11. BIRTHPLACE (State or foreign country): Chester Town
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Briscoe
14. MOTHER'S MAIDEN NAME: Unk. ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): N/O
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: William A. Jenkins
ADDRESS: 10 N Bruce St

MEDICAL CERTIFICATION

I

1B. 331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) C. V. A
DUE TO
(B) MASSIVE INTRACerebral Hemorrhage
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: From 8 AM/PM Apr. 11, 67 to 6 10 AM/PM April 12, 67

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 11 19 67 to April 12 19 67, that (I) (we) last saw the deceased alive on April 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Gary Bae Oh M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: April 12, 67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: BALTO NATIONAL
24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fisher M.D.
25C. FUNERAL DIRECTOR: Marlowe Pettigrew
ADDRESS: 638 N Gilmor St

1967 0 0 3 5 9 6

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
T-600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3589 67-04905 Registered No. 67 3589

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOYCE TYREE

2. DATE AND HOUR PRONOUNCED DEAD: April 11, 1967 10:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 516 N. Mount Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 516 N. Mount Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): S
8. DATE OF BIRTH: March 12-67
9. AGE (In years last birthday):
If Under 1 Yr. Months: 1 Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALBERT TYREE
14. MOTHER'S MAIDEN NAME: YVONNE WADE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Yvonne Wade
ADDRESS: 516 N Mount St

MEDICAL CERTIFICATION

18. 525 X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis [SDII]
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-11-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/13/67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn
23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
24B. NAME OF REGISTRAR: Robert E. Fahey M.D.
24C. FUNERAL DIRECTOR: Thomas P Hayes
ADDRESS: 638 W Gilmor St

VS 151-REV. 1/1/65

1967 0003597

1
14-634

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3590 Registered No. 67 3590

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY J. HARTLOVE

2. DATE AND HOUR PRONOUNCED DEAD: April 11, 1967 5:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore # 21224, 26-07

D. STREET ADDRESS (If rural, give location): 427 S. Macon Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	Divorced	Aug.5,1910	56	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Construction	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John W. Hartlove

14. MOTHER'S MAIDEN NAME: Florence S. McElwee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	1928 - 1934	218-05-3965	Elizabeth C. Bender	Same.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 4/12/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-14-67	Baltimore National Cem.	5501 Frederick Ave. Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 13 1967	Robert E. Falkenna	Charles S. Feiler	901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

67 070 3590

1-400

BIRTH NO. 67 3591

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3591

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Minnie Hall

2. DATE AND HOUR OF DEATH: 4-11-67 | 11:15 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bolton Hill Nursing Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Lutherville Md 53-00

D. STREET ADDRESS (If rural, give location): Valley Rd. Box #485

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 3-8-1884

9. AGE (In years last birthday): 83

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Meekins

14. MOTHER'S MAIDEN NAME: Unk.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ruth Shaffer ADDRESS: Same as #4

MEDICAL CERTIFICATION

1B. 422.1-E 936.9

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia — 6 days

DUE TO

(B) Cardiac failure — Several mos. duration

DUE TO

(C) ASCVD — Several years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary incontinence — Several wks.

CERTIFICATION APPROVED BY: [signature] M.D. CHIEF MEDICAL EXAMINER OR ASST. 4/12/67

19A. DATE OF OPERATION: 3-12-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Subcapital fracture left hip

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-28-67 19 to 4-11-67 19, that (I) (we) last saw the deceased alive on 4-11- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. ~~4-12-67~~

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐

23B. DATE SIGNED: 4-12-67

23C. PHYSICIAN'S NAME (Type): E. Ellsworth Cook, Jr., M.D.

23D. ADDRESS: 2431 Maryland Avenue, Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-14-67

24C. NAME of CEMETERY or CREMATORY: Mt. Olivet Cemetery

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: McCully

ADDRESS: 130 E. Fort Ave. Balto. 30 Md

VS 150-REV. 1/1/65

N 8 20.2

5-364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3592 Registered No. 67 3592

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Stroehla George

2. DATE AND HOUR OF DEATH: Apr. 5th 1967 | 5.07 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Sinai Hospital of Baltimore
(If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): PIKESVILLE 8 53-00
D. STREET ADDRESS (If rural, give location): 18 Maryland Ave Pikesville

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	11/15/01	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pattern Maker	Foundry & Steel	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John J. Stroehla Jr.

14. MOTHER'S MAIDEN NAME: Margaret Tierhoff

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 212-09-7912

17. INFORMANT: Mrs. Ruby William Stroehla
ADDRESS: 18 Maryland Ave Pikesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) Prob. Ca of Kidney — Unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Myocardial Infarction — 5 days

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 29th 1967 to Apr. 5th 1967, that (I) (we) last saw the deceased alive on April 5th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Cieplinski M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/5/67
23C. PHYSICIAN'S NAME (Type): William Cieplinski M.D.
23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 8 1967
24C. NAME of CEMETERY or CREMATORY: Sandy Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fabian M.D.
25C. FUNERAL DIRECTOR: Frank H. Newell Pikesville
ADDRESS:

VS 150-REV. 1/1/65

1 3 6 7 0 0 3 5 9 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-10d

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3593 Registered No. 67 3593

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mrs. EMILY HEBB SCAFFE

2. DATE AND HOUR OF DEATH: April-10-1967 | 11.35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 The House in the Pines 2525 W.Belvedere Av. (21215)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 3040 St.Paul St. (21218)

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: Nov 16, 1874
9. AGE (In years last birthday): 92
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): St. Mary's Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Griffin Hebb
14. MOTHER'S MAIDEN NAME: Betty Cecilia Thompson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO. 217-54-9548
17. INFORMANT: (sister) ADDRESS: Myrtle H. Hance, 3040 St. Paul St., City

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 332 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral thrombosis — 5 weeks
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from March 19 66 to April 10 19 67, that (I) (~~we~~) last saw the deceased alive on April 3 19 67 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 10/67
23C. PHYSICIAN'S NAME (Type): EDWIN JACK BERSTOCK M.D.
23D. ADDRESS: 3500 N CALVERT ST BALTO. 18.

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Apr/12/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): 3801 Frederick Av. 21229

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108-W-North-Av. 21201

VS 150-REV. 1/1/65

0 3 6 0 1

C-628

BIRTH NO. 67 3594

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3594

1. NAME OF DECEASED (Type or Print): Jack M. Carson

2. DATE AND HOUR OF DEATH: Apr. 10, 1967 — 10 33 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kenewaw Nursing Home

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-12

D. STREET ADDRESS (If rural, give location): 3573 Park Heights Ave.,

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 12/9/1880

9. AGE (In years last birthday): 86

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager

10B. KIND OF BUSINESS OR INDUSTRY: Roller Skating Rink

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Carson

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 407-32-4989

17. INFORMANT: Dorothy G. Hughes — ADDRESS: 4200 Edgehill Ave. (11)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 hr.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/1 19 66 to 4/10 19 67, that (I) (we) last saw the deceased alive on 4/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert A. Reiter M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): Robert A. Reiter M.D.

23D. ADDRESS: 606 Edmondson Ave. Balto, Md 21228

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 4-13-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Falkenau

25C. FUNERAL DIRECTOR: G. Howard Strong — ADDRESS: 3207 W. North Ave.,

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-4610

BIRTH NO. 67 3595

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 3595

1. NAME OF DECEASED (Type or Print): COLHOUER, FLORENCE D

2. DATE AND HOUR OF DEATH: APRIL 12, 1967 10:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTIMORE~~ CATONSVILLE 53-00

D. STREET ADDRESS (If rural, give location): FOREST HAVEN NURSING HOME 315 INGLESIDE AVENUE

40

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 12-28-83

9. AGE (In years last birthday): 83

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EDWARD GALLION DEC'D

14. MOTHER'S MAIDEN NAME: UNKNOWN ~~DEC'D~~ ELIZABETH GRIEST

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO. 216 12 5409

17. INFORMANT: HOSPITAL RECORDS-ST. AGNES HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration + Acidosis — 4 wks

DUE TO

(B) Diabetes Mellitus — + 5 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A. S. C V. D -

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No-

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that X(I) (this hospital) attended the deceased from MARCH 10, 1967 to APRIL 12, 1967, that X(I) (we) last saw the deceased alive on APRIL 12, 1967 and that in ~~(my)~~ XX (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ XXXX view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.

23D. ADDRESS: HOSPITAL RECORDS-ST. ~~AGNES~~ AGNES HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-15-67

24C. NAME of CEMETERY or CREMATORY: WESTERN

24D. LOCATION (City, town, or county) (State): BALTIMORE Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fortuna

25C. FUNERAL DIRECTOR: Geo. L. Schwab Funeral Home Francis W. Miller 2101 Frederick Ave ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0 0 0 5 6 0 3

T-650

BIRTH NO. 67 3596

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 3596

1. NAME OF DECEASED (Type or Print): THORN, PAUL C

2. DATE AND HOUR OF DEATH: APRIL 12, 1967 | 5:05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
ST. AGNES HOSPITAL
CATON AND WILKENS AVENUES
BALTO., MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 21207 BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTIMORE~~ CATONSVILLE MANOR.
D. STREET ADDRESS (If rural, give location): 1407 LAFAYETTE AVENUE 53-00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	10-24-96	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DISABLED Stock Handler	~~NONE~~ Livestock	BALTO., MD.	USA

13. FATHER'S NAME: WILL THORN DEC'D

14. MOTHER'S MAIDEN NAME: NELLIE WESTHERSTEIN DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO (If yes, give war or dates of service) NONE

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: 215 07 4435 HOSPITAL RECORDS-ST. AGNES HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Respiratory Arrest.
DUE TO
(B) Acute Myocardial Infarction — 2 days -
DUE TO
(C) Generalize. A-S-C-V-D. — more than 8 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from MARCH 31, 19 67 to APRIL 12, 19 67, that (X) (we) last saw the deceased alive on APRIL 12, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 04-12-67

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MEJIA M.D.

23D. ADDRESS: BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4-15-67	WOODLAWN	WOODLAWN Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	FUNERAL HOME ADDRESS
APR 13 1967	Robert E. Fogler M.D.	GEO. L. SCHWAB	Francis J. Miller 2101 Frederick Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3597 Registered No. 67 3597

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Mayes

2. DATE AND HOUR OF DEATH: 4-10-1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4211 Bayonne Avenue Baltimore, Maryland 21206

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4211 Bayonne Avenue 21206

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 7-26-1899
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales
10B. KIND OF BUSINESS OR INDUSTRY: Hutzlers
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hoerr
14. MOTHER'S MAIDEN NAME: Irma Gabel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-10-6566
17. INFORMANT: Mr Charles Mayes ADDRESS: 7502 Belair Road 21236

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO

(B) Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 6+ years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obesity

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Sept. 9 1966 to 4-10-67 19..., that (I) (~~we~~) last saw the deceased alive on March 10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour ~~and from the causes~~ stated above. (I) (~~We~~) (did) (did not) view the body after death.

23A. SIGNATURE: Charles M. Kerr M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-11-67
23C. PHYSICIAN'S NAME (Type): Charles M. Kerr M.D.
23D. ADDRESS: 6801 Belair Rd. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-12-1967
24C. NAME of CEMETERY or CREMATORY: St. Michael's Cemetery
24D. LOCATION (City, town, or county) (State): Perry Hall Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Falkenau
25C. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 7401 Belair Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

O-416

BIRTH NO. 67 3598

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3598

1. NAME OF DECEASED (Type or Print): OLVER CATHERINE E.

2. DATE AND HOUR OF DEATH: 1 45 Am -4-9-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL 40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 288 Laverne Ave #27

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 8-14-1884
9. AGE (In years last birthday): 82
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Savage, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Lot Whitehead
14. MOTHER'S MAIDEN NAME: Mary Turner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-54-7693
17. INFORMANT: Mrs. Ruth Becker, 300 Laverne ADDRESS: 21227 (daughter)

MEDICAL CERTIFICATION

1B. 420.1 X 260 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction1 — Acute(1/2 hr)

DUE TO

(B) Arteriosclerotic Cardiovascular Heart Disease — 20 yrs.

DUE TO

(C) Arteriosclerosis, Generalized, Senile — 20 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus, Mild; Nephrosclerosis — 30 years

19A. DATE OF OPERATION: 0 --
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: --
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? --

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): none
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ none
21F. HOW DID INJURY OCCUR? none

22. I certify that (I) (this hospital) attended the deceased from 1961 19 to April 9 19 67, that (I) (we) last saw the deceased alive on April 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 9, 1967
23C. PHYSICIAN'S NAME (Type): Anthony J. Young, M.D. M.D.
23D. ADDRESS: 410 Westshire Drive, Balto., Md. 21228

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-12-67
24C. NAME of CEMETERY or CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Avenue 29 ADDRESS:

VS 150-REV. 1/1/65

0 3 6 0 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-636

BIRTH NO. 67 3599

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3599

1. NAME OF DECEASED (Type or Print): ANNA B. CARTER

2. DATE AND HOUR OF DEATH: April 9, 1967 | 10:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

410 Colleen Road
Baltimore, Maryland

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-31

D. STREET ADDRESS (If rural, give location): 410 Colleen Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-11-99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Schnappinger

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-34-1442

17. INFORMANT: Mr. Ernest L. Carter, 410 Colleen Road 21229

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — immediate

DUE TO

(B) Coronary artery occlusion

DUE TO

(C) Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

osteoarthritis — 20 yrs

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 1962 to Feb 1967, that (I) (we) last saw the deceased alive on Feb 28, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: H H Baylus M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 11 April 67

23C. PHYSICIAN'S NAME (Type): Dr. Herman Baylus M.D.

23D. ADDRESS: 1600 Wilkens Avenue

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-12-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fogler M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

03607

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3600 Registered No. 67 3600

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BESSIE C. MENCHEY

2. DATE AND HOUR OF DEATH: APRIL 10, 1967 9:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 BON SECOURS HOSP. BALTIMORE MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 8507 GREEN'S LANE

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 10-3-98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME: GEORGE LAWRENCE MARK

14. MOTHER'S MAIDEN NAME: LUELLA KATE MORRIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: PATIENT'S CHART ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 603X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) UREMIA

DUE TO

(B) ACUTE TUBULAR NECROSIS

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-3-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CLOSURE OF COLOSTOMY

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 1, 1967 to APRIL 10, 1967, that (I) (we) last saw the deceased alive on APRIL 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Adolfo G. de Perio M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): ADOLFO G. DE PERIO M.D.

23D. ADDRESS: BON SECOURS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/13/67

24C. NAME of CEMETERY or CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Foulks, M.D.

25C. FUNERAL DIRECTOR: Austin C. Donovan

ADDRESS: 3818 Roland Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

67 0 0 3 6 0 8

T-260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3601 Registered No. 67 3601

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Hazel I. Tasker

2. DATE AND HOUR OF DEATH: April 10, 1967 | 5.45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 615 McKewin Ave

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-05
D. STREET ADDRESS (If rural, give location): 2956 Keswick Road

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: June 3, 1912
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Raymond T. Holmes
14. MOTHER'S MAIDEN NAME: Emma E. Fuhrman.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Betty L. Byus. ADDRESS: 615 McKewin Ave. # 18

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 174 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Carcinoma of Uterus c
DUE TO
(B) generalized metastasis
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Mar 27 1967 to April 10 1967, that (I) (~~we~~) last saw the deceased alive on April 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: L B Stevens M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/11/67
23C. PHYSICIAN'S NAME (Type): L. B. STEVENS M.D.
23D. ADDRESS: 3400 ERDMAN AVE

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/15/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Memorial
24D. LOCATION (City, town, or county) (State): Wash. Blvd, Md

25A. DATE RECEIVED BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: Austin E. Donovan ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-1145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3602 Registered No. 67 3602

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nathan Caplan

2. DATE AND HOUR OF DEATH: April 10th 1967 | 3.20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-19
D. STREET ADDRESS (If rural, give location): 3411 Glen Ave. # 15

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: [redacted]
9. AGE (In years last birthday): 84 [redacted]
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POULTRY
10B. KIND OF BUSINESS OR INDUSTRY: RETAIL - WHOLESALE
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: MRS. ESTHER CAPLAN, 3411 GLEN AVENUE
ADDRESS: # 15

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 560.4 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration Pneumonia — 48 hours
DUE TO
(B) G. I. bleeding — 5 days
DUE TO
(C) Hiatus Hernia — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD H.CVD — Unknown

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Apr. 6th 19 67 to April 10th 19 67, that (I) (we) last saw the deceased alive on Apr. 10th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Cieplinski M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): William Cieplinski M.D.
23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/11/67
24C. NAME of CEMETERY or CREMATORY: BOBROISKER BENEFICIAL CIRCLE
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Foley
25C. FUNERAL DIRECTOR: SOLIEVINSON & BROS. INC.
ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640

BIRTH NO. 67 3603

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3603

1. NAME OF DECEASED (Type or Print): William Brawley

2. DATE AND HOUR OF DEATH: 4/10/67 | 6 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 1210 H COURT

5 - 01

5. SEX: MALE

6. RACE: NEGROID

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 4-29-96

9. AGE (In years last birthday): 70

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JIM BROWLEY

14. MOTHER'S MAIDEN NAME: DAPHNEY ASH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-03-6372

17. INFORMANT: Ethel Dorman

ADDRESS: 1167 Bond St

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarct — 1 day

DUE TO

(B) A S CVD — years

DUE TO

(C) also tension pneumothorax — ~2 hrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Chronic Lung Disease, Aspiration

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 4/9 1967 to 4/10 1967, that I (we) last saw the deceased alive on 4/10 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: S W Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): S.W. SPAULDING M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-13-67

24C. NAME of CEMETERY or CREMATORY: Mt Cahary Cem

24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE RECEIVED BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Tucker M.D.

25C. FUNERAL DIRECTOR: Elroy O. Wilson

ADDRESS: 100 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-96-50 J-525
FR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3604 Registered No. 67 3604

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Isaiah L. Johnson

2. DATE AND HOUR OF DEATH: 4/10/67 | 7 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Baltimore City Hospitals
(If not in hospital or institution, give street address or location): 4940 Eastern Avenue, Baltimore, Maryland 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
8-02
D. STREET ADDRESS (If rural, give location): 1827 Duncan Street 21213

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 1-3-1913
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R. R. Trackman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Howard Johnson
14. MOTHER'S MAIDEN NAME: Carrie Robinson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 717-07-5705
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue 21224
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) DUE TO: Ca of (R) tonsil, — 3 yrs
(B) DUE TO: recurrent c̄ metastases
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/28 1967 to 4/10 1967, that (I) (we) last saw the deceased alive on 4/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R J Owellen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): Dr. Richard J. Owellen M.D.
23D. ADDRESS: Baltimore City Hospitals, 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-14-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Gloyd W. Wilson
ADDRESS: 1000 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-5251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3605 Registered No. 67 3605

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY JENKINS

2. DATE AND HOUR OF DEATH: 4-9-67 6:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 38

(If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTIMORE, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: BALTO. CITY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 17-01

D. STREET ADDRESS (If rural, give location): CARVER NURSING HOME 607 PENNA. AVE. #1

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 9-24-83

9. AGE (In years last birthday): 83

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: CARRIE WIDE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 598X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 4/1 1967 to 4/9 1967, that I (we) last saw the deceased alive on 4/9 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bernard du Bois M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/9/67

23C. PHYSICIAN'S NAME (Type): Bernard du Bois M.D.

23D. ADDRESS: University Hospital, Balt.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/13/67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): Glen Burnie Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Taylor

25C. FUNERAL DIRECTOR: John P. Carroll

ADDRESS: 1712 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-3210

L-200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3606 Registered No. 67 3606

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Maddox Mrs Sadie (LAWS)

2. DATE AND HOUR OF DEATH 4/11/67 - 7:15 a.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-11
D. STREET ADDRESS (If rural, give location) 3303 Dolfield Av.

5. SEX F 6. RACE N 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH 2-6-09 9. AGE (In years last birthday) 58 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME George Laws. 14. MOTHER'S MAIDEN NAME Rebecca Nichols.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 667955 17. INFORMANT John Maddox ADDRESS 3303 Dolfield

MEDICAL CERTIFICATION

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ~~Diabetic Acidosis~~ (?)
DUE TO
(B) Coronary Insufficiency — 3 yrs
DUE TO
(C) Diabetes Mellitus — 10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not White At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 3 - November 1967 to April 11 1967, that ~~I~~ (we) last saw the deceased alive on April 11 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE Alfred T. Cox ~~M Young Kim M.D.~~ M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 4/11/67

23C. PHYSICIAN'S NAME (Type) Alfred T. Cox M.D. 23D. ADDRESS Church Home and Hospital Balto. Md. 21231

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/15/67 24C. NAME of CEMETERY or CREMATORY Arlington Memorial Pk 24D. LOCATION (City, town, or county) Arlington (State) Md

25A. DATE REC'D BY HEALTH DEPT. APR 13 1967 25B. NAME OF REGISTRAR Robert E. Sydney M.D. 25C. FUNERAL DIRECTOR Joseph G. Lock Jr. ADDRESS 1304 N. Central

VS 150-REV. 1/1/65

W-421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3607 Registered No. 25 25 78 67 3607

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): George Wilson

2. DATE AND HOUR OF DEATH: 4-12-67 12 15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-32
D. STREET ADDRESS (If rural, give location): 3055 Ascension St 21225

5. SEX: Male
6. RACE: Negroe
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2-1-15
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wire Bundler
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas E. Wilson
14. MOTHER'S MAIDEN NAME: Mary Steward

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-05-5064
17. INFORMANT: ADDRESS: 3055 Ascension ST

MEDICAL CERTIFICATION

18. 572.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ? Peritonitis ? Bleeding ulcer, stomach
DUE TO
(B) ? Multiple diverticulosis of Lt. Colon — 3/17/67 to 4/12/67
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 3/23/67, 4/1/67, 4/7/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: diverticulitis, perit. abscess; gi hemorrhage
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/17 1967 to 4/12 1967, that (I) (we) last saw the deceased alive on 4/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: DR. Robert McCurdy / Youngsik Moon, M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/12/67
23C. PHYSICIAN'S NAME (Type): Robert McCurdy / Youngsik Moon
23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: Balto. National
24D. LOCATION (City, town, or county) (State): 5501 Frederick Av

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fo[illegible]
25C. FUNERAL DIRECTOR: Joseph F. Lock Jr
ADDRESS: 1504 N. Central Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Toogood, Helen
40-74-87 T-2301

THE BODY OF HELEN TOOGOOD WAS RELEASED BY DOCTOR HIRSCH
OF THE MEDICAL EXAMINER'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3608

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3608

1. NAME OF DECEASED (Type or Print): HELEN TOOGOOD

2. DATE AND HOUR OF DEATH: 4-11-67 10.30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 9-09
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1638 HARFORD ROAD 21213

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 9-22-24
9. AGE (In years last birthday): 42
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JORDAN, Charles E.
14. MOTHER'S MAIDEN NAME: CARRIE
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles H. Toogood
ADDRESS: 713 Eislen St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) CVA - Post. fossa - hem SAH
DUE TO
(B) Hypertension
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-11 1967 to 4-11 1967, that (I) (we) last saw the deceased alive on 4-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John S. Sergent, MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/11/67
23C. PHYSICIAN'S NAME (Type): JOHN S. SERGENT M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Finkey M.D.
25C. FUNERAL DIRECTOR: Charles A. Rice
ADDRESS: 661 W. Barre St.

VS 150-REV. 1/1/65

3616

A-6521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3609 Registered No. 67 3609

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary F. Armacost

2. DATE AND HOUR OF DEATH: April 12, 1967 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5705 The Alameda

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21212
D. STREET ADDRESS (If rural, give location): 5705 The Alameda

00 27-38

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: June 10, 1904.
9. AGE (In years last birthday): 62
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis W. Stringer
14. MOTHER'S MAIDEN NAME: Emma C. Middlekauf

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-09-3999
17. INFORMANT: Mr. William E. Armacost
ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 WKS

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/20 19 67 to 4/12 19 67, that (I) ~~(we)~~ last saw the deceased alive on 4/10 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Robert E May M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): Dr. Robert E. May M.D.
23D. ADDRESS: 5662 The Alameda, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/15/67.
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Foulkrod
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: 5305 Harford Rd. #14

VS 150-REV. 1/1/65

3617

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-62b

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3610 Registered No. 67 3610

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BERTHA LILLIAN KRAUSCH

2. DATE AND HOUR OF DEATH: April 17, 1967. 11 00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3009 Woodring Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-05

D. STREET ADDRESS (If rural, give location): 3009 Woodring Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: August 22, 1894

9. AGE (In years lost birthday): 72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George S. Nun

14. MOTHER'S MAIDEN NAME: Amelia Salisbury

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-03-3057

17. INFORMANT: Mrs. Dorothy M. Carroll ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Coronary Thrombosis — 1 day

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1965 to April 12th 1967, that (I) (we) last saw the deceased alive on March 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George H. Beck M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): George H. Beck M.D.

23D. ADDRESS: 6012 Harford Rd, Balto, Md 21214

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/15/67.

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fuchs

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

0 3 6 1 8

1 ~~18~~ 10

H-520

67 3611
BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3611

1. NAME OF DECEASED (Type or Print): HORACE A. HEINZE

2. DATE AND HOUR PRONOUNCED DEAD: April 9, 1967 12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40/99 St. Agnes Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville 53-00

D. STREET ADDRESS (If rural, give location): 165 Cherrydell Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Cauc.	2-17-12	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Bugle Laundry	Germany	USA

13. FATHER'S NAME: Anthur Heinze

14. MOTHER'S MAIDEN NAME: Anna Franke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-05-0571

17. INFORMANT: Mrs. Horace A. Heinze ADDRESS: 165 Cherrydell Rd. - 21228

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-13-67	Loudon Park Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 13 1967	[illegible]	Witzke F. D.	4101 Edmondson Ave.

VS 151-REV. 1/1/65

1967 000 3619

4/ 1P. 324 67 3612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3612

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PETZOLD, MARTHA J.

2. DATE AND HOUR OF DEATH: APRIL 10, 1967 | 9:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE 53-00

D. STREET ADDRESS (If rural, give location): 428 STRATFORD ROAD

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-4-~~88~~ 88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? ~~UNKNOWN~~ USA

13. FATHER'S NAME: THEODORE UHLIG

14. MOTHER'S MAIDEN NAME: MARIA UHLIG (MAIDEN NAME UNKNOWN)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: HOSPITAL RECORDS-ST. AGNES HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. I 420.1 I-162.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ACUTE MYOCARDIAL INFARCTION — APROX. 2 WEEKS

DUE TO

(B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO

(C) BRONQUIOGENIC CARCINOMA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that X (1) (this hospital) attended the deceased from MARCH 11, 19 67 to APRIL 10, 19 67, that (X) (we) last saw the deceased alive on APRIL 10, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Revilla M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): R. REVILLA M.D.

23D. ADDRESS: ST. AGNES HOSPITAL; CATON & WILKENS AVES 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-14-67

24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave. ADDRESS:

VS 150-REV. 1/1/65

3620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6 G-6

BIRTH NO. 67 3613

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3613

1. NAME OF DECEASED (Type or Print): Allen R Griffith

2. DATE AND HOUR OF DEATH: 4-11-67 | 12:35 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #212 38

D. STREET ADDRESS (If rural, give location): 607 Wyeth St. 21-02

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12-5-1887

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Maintenance Man

10B. KIND OF BUSINESS OR INDUSTRY: Koester Bakery

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - Allen Griffith

14. MOTHER'S MAIDEN NAME: Unk.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-10-9926A

17. INFORMANT: Mrs. Mary E. Griffith

ADDRESS: 607 Wyeth Street - 21230

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema marked. — Years

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-11 1967 to 4-11 1967, that (I) (we) last saw the deceased alive on 4-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William J. Marek M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): William J. Marek M.D.

23D. ADDRESS: 1213 Light St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-14-67

24C. NAME OF CEMETERY or CREMATORY: Glen Haven Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fankenna

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

VS 150-REV. 1/1/65

67 003621

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Date Unknown Injuries

Employee Worked Years

William J. Work

2 F-030

BIRTH NO. 67 3614

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3614

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): FORD, Elmer

2. DATE AND HOUR OF DEATH: 4-12-67 | 5:45 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-31

D. STREET ADDRESS (If rural, give location): 584 Lucia Avenue

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 10-10-92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ford, Amiel

14. MOTHER'S MAIDEN NAME: Johnson, Lucritia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Elmer Ford ADDRESS 584 Lucia Ave. -21229

Admission Sheet

MEDICAL CERTIFICATION

18. I 163 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Jaundice

DUE TO

(B) Metastatic carcinoma

DUE TO

(C) Carcinoma, (?) lung

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/8 1967 to April 12 1967, that (I) (we) last saw the deceased alive on April 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. H. Ghilardi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): Abdolhamid Ghilardi M.D.

23D. ADDRESS: Bon Secours Hospital.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/15/67

24C. NAME of CEMETERY or CREMATORY: Meadowridge Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Talley M.D.

25C. FUNERAL DIRECTOR: Witzke F. D. ADDRESS 4101 Edmondson Ave.

VS 150-REV. 1/1/65

R 231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3615 Registered No. 67 3615

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mrs. Eva Maud Royston

2. DATE AND HOUR OF DEATH: April 7, 1967 3 15 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Reisterstown 53-00

D. STREET ADDRESS (If rural, give location): 206 Conwood Ave

5. SEX: F. 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: May 20 ~~[illegible]~~, 1900 9. AGE (In years last birthday): 66

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Haines

14. MOTHER'S MAIDEN NAME: Grace Winter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: John W. Royston, Jr. ADDRESS: 9604 9th Ave. 21234

MEDICAL CERTIFICATION

18. 260 X X E 954 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ~~ASCVD~~ Arteriosclerotic Cardiovascular Disease with Ventricular Fibrillation During Anesthesia

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

~~Ventricular Fibrillation during Anesthesia for amputation of left leg~~ Diabetes Mellitus with Gangrene of Left Leg ~~Gangrenous leg. Diabetes Mellitus~~

CERTIFICATION APPROVED BY: [signature] M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: April 7, 1967

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene Left Leg

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): Dr Springate

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): OR #4

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Mercy Hospital

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4 / 7 / 67 2 00 p

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? Ventricular Fibrillation During Anesthesia for Leg Amputation

22. I certify that (I) (this hospital) attended the deceased from March 30 1967 to April 7 1967, that (I) (we) last saw the deceased alive on April 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wm Gregory Bruce M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: April 7, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/10/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith

24D. LOCATION (City, town, or county) (State): Baltimore Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Wilbert E. Johnson ADDRESS: 8521 Loch Raven B'l.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

U-514

BIRTH NO. 67 3616

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3616

1. NAME OF DECEASED (Type or Print): FRANCIS J. UMPLEBY

2. DATE AND HOUR PRONOUNCED DEAD: April 9, 1967 | 5:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 650 Dumbarton Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-01

D. STREET ADDRESS (If rural, give location): 650 Dumbarton Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Sept. 8, 1916	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Engineer	Sales	Maryland	U.S.A.

13. FATHER'S NAME: Francis J. Umpleby

14. MOTHER'S MAIDEN NAME: Marie L. Laubert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WWII	212-03-7607	Margaret L. Umpleby	742 Weatherbee R

MEDICAL CERTIFICATION

18. 571.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/12/67	Baltimore National	Baltimore Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 13 1967	Robert E. Faulkner	William E. Johnson	8521 Loch Raven

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 6 2 4

C-500

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3617 Registered No. 67 3617

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth V. Conway

2. DATE AND HOUR OF DEATH: April 6, 1967 8:30P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Ardleigh Nursing Home 2095 Rockrose Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-08
D. STREET ADDRESS (If rural, give location): 2095 Rockrose Ave.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 7/17/80
9. AGE (In years last birthday): 86 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 217-03-9472
17. INFORMANT: James J. Mulligan — ADDRESS: 8519 Loch Raven

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis with hemiplegia (rt.) — 4 yrs.
DUE TO
(B) Arteriosclerotic cardio-vascular disease — 4 yrs.
DUE TO
(C) Diabetes mellitus — 4 yrs.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Osteoarthritis generalized

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 9, 1963 to April 6, 1967, that (I) (~~we~~) last saw the deceased alive on April 5, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Apr. 7, 1967
23C. PHYSICIAN'S NAME (Type): Lloyd Saylor M.D.
23D. ADDRESS: 3902 Greenmount Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/10/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Lloyd E. Falkenna
25C. FUNERAL DIRECTOR: Wm. E. [illegible] — ADDRESS: 8521 Loch Raven

VS 150-REV. 1/1/65

5-100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3618 Registered No. 67 3618

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SEIPP, BERNARD OSCAR

2. DATE AND HOUR OF DEATH: April 10, 1967 | 11:35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 6209 Chinquapin Parkway

27-38

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9/22/16

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Mech.

10B. KIND OF BUSINESS OR INDUSTRY: Engleside Welding C.

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence Seipp

14. MOTHER'S MAIDEN NAME: Della Schawland

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): 2/1/44 - 12/22/45

16. SOCIAL SECURITY NO.: 216-10-8114

17. INFORMANT: VA Hospital Records

ADDRESS: Baltimore, Maryland 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

13-1X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): (A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/19/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Exploratory Laporatomy

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 7th 19 66 to April 10th 19 67, that (I) (we) last saw the deceased alive on April 10th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard F. Kieffer Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: April 10, 1967

23C. PHYSICIAN'S NAME (Type): RICHARD F. KIEFFER, JR. M.D.

23D. ADDRESS: VA Hospital 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/13/67

24C. NAME of CEMETERY or CREMATORY: Prospect Hill

24D. LOCATION (City, town, or county) (State): Towson Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: William E. Johns

ADDRESS: 8521 Loch Raven B'lvd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3619 Registered No. 67 3619

M.E. CASE NO. M.

1. NAME OF DECEASED (Type or Print): Mitchell, Ethel

2. DATE AND HOUR OF DEATH: 4/10/67 1:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland & COUNTY: Harford Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Havre de Grace 62-00

D. STREET ADDRESS (If rural, give location): RD #2

5. SEX: Female

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 04/21/94

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Griffin Mitchell

14. MOTHER'S MAIDEN NAME: Kennedy - Carrie V.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: unkn.

17. INFORMANT: admission record ADDRESS

18. 334 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aneurysm of internal carotid artery & cavernous portion — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Symptoms 3½ wks.

DUE TO

(C) — INTERVAL BETWEEN ONSET AND DEATH: "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 4/7

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Internal carotid aneurysm

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): NONE

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 03/28 1967 to 4/10 1967, that (I) (we) last saw the deceased alive on 4/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fred R. Eilber M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): Fred R. Eilber. M.D.

23D. ADDRESS: Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 12 1967

24C. NAME of CEMETERY or CREMATORY: Rock Run Cem.

24D. LOCATION (City, town, or county) (State): Harford Co. Md

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Tarlow

25C. FUNERAL DIRECTOR: R. Madison Mitchell ADDRESS: Havre de Grace Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-258

BIRTH NO. 67 3620

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3620

1. NAME OF DECEASED (Type or Print): Elizabeth LEE Wagner

2. DATE AND HOUR OF DEATH: April 10, 1967 | 8 30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: —

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-10

D. STREET ADDRESS (If rural, give location): 3309 E. Baltimore St

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: MAR. 23, 1913

9. AGE (In years last birthday): 54

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES E. GROVER

14. MOTHER'S MAIDEN NAME: FRANCINIVA MAY GORDON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: CHARLES F. WAGNER, ADDRESS: 3009 E. BALTO. ST Balt. MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ACUTE MYOCARDIAL INFARCTION — RECENT

DUE TO

(B) CORONARY ARTERY DISEASE — CHRONIC

DUE TO

(C) DIABETES MELLITUS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC RENAL DISEASE

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 17 1967 to Feb 23 1967, that (I) (we) last saw the deceased alive on Feb 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: April 10, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: APR. 15 1967

24C. NAME of CEMETERY or CREMATORY: BEL AIR MEMORIAL GARDENS

24D. LOCATION (City, town, or county) (State): BEL AIR MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fabian M.D.

25C. FUNERAL DIRECTOR: R. Madison Mitchell, ADDRESS: Havre de Grace, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200

BIRTH NO. 67 3621

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3621

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH BUSCH

2. DATE AND HOUR PRONOUNCED DEAD: April 11, 1967 9:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 24 W. Franklin St.
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Washington, D. C.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): V-48
D. STREET ADDRESS (If rural, give location): 220 H Street, N. E.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 12/27/1900
9. AGE (In years last birthday): 66
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harrison F. Busch
14. MOTHER'S MAIDEN NAME: Edna ? Goucler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hanlon Funeral Home
ADDRESS: 4748 Wisconsin Ave. N.W Washington, D. C.

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz, M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 4-11-67

23A. BURIAL CREMATION, REMOVAL (Specify): Removal
23B. DATE: 4/12/1967
23C. NAME of CEMETERY or CREMATORY:
23D. LOCATION (City, town, or county) (State): Washington, D. C.

24A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
24B. NAME OF REGISTRAR: Robert E. Fackenna
24C. FUNERAL DIRECTOR: Wm. Tuhman
ADDRESS: Balto., Md. Smithsburg, Pa.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 6 2 9

G-640

BIRTH NO. 67 3622

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3622

1. NAME OF DECEASED (Type or Print): JULIUS F. GRAUEL

2. DATE AND HOUR OF DEATH: April 11, 1967 | 1 30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-09

D. STREET ADDRESS (If rural, give location): 1814 INGRAM ROAD

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 10-14-76

9. AGE (In years last birthday): 90

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - Clergyman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MINNESOTA

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: GRAUEL, Julius H.

14. MOTHER'S MAIDEN NAME: LOUISA ROENTGEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 215-50-4036

17. INFORMANT: Miss Louise A. Grauel

ADDRESS: 1705 Aberdeen Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE GI. BLEEDING

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 04-09 1967 to 04-11 1967, that (I) (we) last saw the deceased alive on 04-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY, M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/14/1967

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Wm. Tillman Sons

ADDRESS: Balto., Md. north Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3623 Registered No. 67 3623

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gladys M. Kaufmann

2. DATE AND HOUR OF DEATH: April 11, 1967 | 1A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): House in the Pines - Belair

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4623 Asbury Avenue 21206

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	May 13, 1902	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Electronics	Assembler	Maryland	

13. FATHER'S NAME: Reinhart

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Mr. William Bostion	5901 Daybreak

MEDICAL CERTIFICATION

18. 420.0 41 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic Heart Disease — 8 YRS.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 10 YRS

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 15 1960 to April 11 1967, that (I) (we) last saw the deceased alive on April 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Leon E. Kassel M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): LEON E. KASSEL M.D.

23D. ADDRESS: 3501 ST. PAUL ST. BALTIMORE 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/14/1967	Belair Memorial Cemetery	Belair, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 13 1967	Robert E. Fisher M.D.	W.M.F. Tichner & Sons	Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620

Pennsylvania

BIRTH NO. 67 3624

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3624

1. NAME OF DECEASED (Type or Print): Timothy Dwayne Percy

2. DATE AND HOUR OF DEATH: April 9, 1967 2:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: Washington Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Hancock 71-00

D. STREET ADDRESS (If rural, give location): Rt. 1 Rice Rd.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): child

8. DATE OF BIRTH: 4/20/62

9. AGE (In years last birthday): 4

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Percy

14. MOTHER'S MAIDEN NAME: June Truax

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Records- US PHS Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

I. 204.3

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: (A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Acute lymphatic leukemia — Months

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar. 21 19 67 to Apr. 9 19 67, that (I)(we) last saw the deceased alive on Apr. 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael E. Pelczar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/10/67

23C. PHYSICIAN'S NAME (Type): Michael E. Pelczar, SA Surgeon (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4.12.67

24C. NAME of CEMETERY or CREMATORY: MAY, S CHAPEL

24D. LOCATION (City, town, or county) (State): FULTON COUNTY PENNA.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Howard J. Stone Hancock Md. ADDRESS

VS 150-REV. 1/1/65

67 0 0 3 6 3 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-5201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3625 | Registered No. 67 3625

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN JAMES

2. DATE AND HOUR OF DEATH: 4-9-1967 | 9.50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 NORTH CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE Edgemere 53-00
D. STREET ADDRESS (If rural, give location): 2109 LINCOLN AVE.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 6-4-03
9. AGE (In years last birthday): 63
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John James
14. MOTHER'S MAIDEN NAME: Eva Gephard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-07-8393
17. INFORMANT: NORTH CHARLES GEN. HOSP. CHART
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial infarction — 1 hour

DUE TO

(B) A.S.C.V.D — 5-7 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-5 1967 to 4-9 1967, that (I) (we) last saw the deceased alive on 4-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Juan F. Alemar M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-9-1967
23C. PHYSICIAN'S NAME (Type): RAYMOND RANGLE M.D.
23D. ADDRESS: 2938 St. Paul St. BALTIMORE 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/13/67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: John J. Duda
ADDRESS: 7922 Wise Ave. Dundalk, Md.

3633

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-00-00 DH 15-552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3626

BIRTH NO.

M.E. CASE NO. 67 3626

1. NAME OF DECEASED (Type or Print): Alice Simmons — Alice Simmons

2. DATE AND HOUR OF DEATH: 4-9-67 | 7 06 P.M.

CERTIFICATE AMENDED 4-20-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dundalk
53-00
D. STREET ADDRESS (If rural, give location): 2701 Page Drive #21222

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1-6-26
9. AGE (In years last birthday): 41
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. a.

13. FATHER'S NAME: Frank Neville
14. MOTHER'S MAIDEN NAME: Mabel ~~Abbotts~~ Abbott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-24-2890
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue, Baltimore, Maryland #21224 — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 3-01 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asthmatic Bronchitis — 6 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4-3 19 67 to 4-9 19 67, that (I) ~~(we)~~ last saw the deceased alive on 4-9 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: David J. Mishelevich M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4·9·67.
23C. PHYSICIAN'S NAME (Type): David J. Mishelevich M.D.
23D. ADDRESS: 4940 Eastern Avenue Baltimore, Md. #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/13/67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Fowler M.D.
25C. FUNERAL DIRECTOR: John J. Duda — ADDRESS: 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

3 6 3 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3627 Registered No. 67 3627

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Louise V. Black — Louise V. Black

2. DATE AND HOUR OF DEATH: April 10, 1967 | 5:40 P.M.

CERTIFICATE AMENDED 4-18-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Dundalk 53-00
D. STREET ADDRESS (If rural, give location): 8203 Rosebank Rd 21222

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 9/18/1913
9. AGE (In years last birthday): ~~54~~ 53 — If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Arthur Gesell
14. MOTHER'S MAIDEN NAME: Louise Iserell
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 219-10-4422
17. INFORMANT: Stephen J. Black — ADDRESS: Same

MEDICAL CERTIFICATION

1B. 410X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Rheumatic Heart Disease

DUE TO

& mitral stenosis & insufficiency

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 7 1967 to April 10 1967, that (I) (we) last saw the deceased alive on April 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): Michael Gould M.D.
23D. ADDRESS: Md. General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 14-1967
24C. NAME of CEMETERY or CREMATORY: Sacred Heart of Jesus
24D. LOCATION (City, town, or county) (State): German Hill Rd. Dundalk, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 13 1967
25B. NAME OF REGISTRAR: Robert E. Stalnaker
25C. FUNERAL DIRECTOR: John J. Duda, Dundalk, Maryland ADDRESS: 21222

VS 150-REV. 1/1/65

67 3627

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 4-18-67 M.H.

M-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3628 Registered No. 67 3628

M.E. CASE NO. 67-08408

1. NAME OF DECEASED (Type or Print): Baby Boy Maxwell

2. DATE AND HOUR OF DEATH: 3/20/67 1:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-03

D. STREET ADDRESS (If rural, give location): ~~XXXXXXXXXX~~ 2722 E. ~~Orliner St~~ Oliver St

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Infant

8. DATE OF BIRTH: 3/19/67

9. AGE (In years last birthday): Newborn

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 4 Min.: 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): The Johns Hopkins Hosp.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Maxwell

14. MOTHER'S MAIDEN NAME: Clara Parker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 773.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Respiratory Insufficiency

DUE TO

(B) Prematurity

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/19 19 67 to 3/20 19 67, that (I) (we) last saw the deceased alive on 1:30 Am 3/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph Kaplan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 3/20/67

23C. PHYSICIAN'S NAME (Type): Joseph Kaplan M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 3/20/67

24C. NAME of CEMETERY or CREMATORY: The Johns Hopkins Hosp.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE RECEIVED BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL ADDRESS:

VS 150-REV. 1/1/65

1 5 6 / 0 0 3 6 3 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L512 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3629 67-06901

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3629

1. NAME OF DECEASED (Type or Print): BABY GIRL LUMPKINS

2. DATE AND HOUR OF DEATH: 4/9/67 | 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 25-32

D. STREET ADDRESS (If rural, give location): 2523 SEAMON HILL AVE 21225

5. SEX: F

6. RACE: COLORED

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 4/9/67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 2 Min.: 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES LUMPKINS

14. MOTHER'S MAIDEN NAME: PEARL MARIE WEAVER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: " " " ADDRESS: 2523 SEAMON HILL AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 776 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/9/1967 to 4/9/1967, that (I) (we) last saw the deceased alive on 4/9/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Tomas A. Alvero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): TOMAS A. ALVERO M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): DISPOSAL

24B. DATE:

24C. NAME of CEMETERY or CREMATORY: FR. SQ. HOSP. DISPOSAL

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahrenna

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL

ADDRESS:

VS 150-REV. 1/1/65

1967 00 3637

R-120

BIRTH NO. 67 3630

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3630

1. NAME OF DECEASED (Type or Print): JACK RIBAKOW

2. DATE AND HOUR OF DEATH: 4/11/67 645 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21215 28-31

D. STREET ADDRESS (If rural, give location): 5532 NOME AVE 21215

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: [redacted]

9. AGE (In years last birthday): [redacted] 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF-EMPLOYED

10B. KIND OF BUSINESS OR INDUSTRY: MFG. REPRESENTATIVE

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Solomon RIBAKOW

14. MOTHER'S MAIDEN NAME: Mamie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: MRS. IDA RIBAKOW, ADDRESS: 5532 NOME AVENUE #15

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Chronic ulcerative colitis — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs.

DUE TO

(B) ? Acute Myocardial infarction

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/28/67 1967 to 4/11 1967, that (I) (we) last saw the deceased alive on 4/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allen Ginsberg M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): ALLEN GINSBERG M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/12/67

24C. NAME of CEMETERY or CREMATORY: HEBREW FRIENDSHIP

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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A-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3631 Registered No. 67 3631

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): H. JACK [redacted] ALK

2. DATE AND HOUR OF DEATH: 4/11/67 | 12:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-17
D. STREET ADDRESS (If rural, give location): 2812 OAKLEY AVENUE #15

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	12/21/1903	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSURANCE	SALESMAN	RUSSIA	USA

13. FATHER'S NAME: MORRIS ALK

14. MOTHER'S MAIDEN NAME: IDA COHEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: MRS. ETTA ALK, 2812 OAKLEY AVENUE #15 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA

DUE TO

(B) PROBABLE OBSTRUCTIVE UROPATHY

DUE TO

(C) METASTATIC CARCINOMA OF BREAST

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-5-67	BIOPSY	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-1- 1967 to 4-11 1967, that (I) (we) last saw the deceased alive on 4-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jay Martin Barrash M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): JAY MARTIN BARRASH M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4/12/67	MIKRO KODESH BETH ISRAEL	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3632 Registered No. 67 3632

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John J. Schonowski

2. DATE AND HOUR OF DEATH: 4-9-67 | 6:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - 21225 23-04

D. STREET ADDRESS (If rural, give location): 3703 Third St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	widowed	June 4, 1902	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Automobile	Baltimore, Maryland	U.S.

13. FATHER'S NAME: Francis Schonowski

14. MOTHER'S MAIDEN NAME: Matilda

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-03-7132

17. INFORMANT: John J. Schonowski, Jr., - same ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — 4 hours

DUE TO

(B) Arteriosclerotic Ht disease — 10 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ventricular fibrillation

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work / Not While At Work	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4:00 pm 4/9 1967 to 6:30 pm 4/9 1967, that (I) (we) last saw the deceased alive on 6:30 pm 4/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rifat Abousy M.O. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/9/67

23C. PHYSICIAN'S NAME (Type): Rifat Abousy M.O.

23D. ADDRESS: 1218 Light St Balto Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-13-1967	Holy Cross Cemetery	Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 14 1967	Robert E. Farley M.D.	George J. Gonce	4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3633 Registered No. 67 3633

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH DE MONTE

2. DATE AND HOUR OF DEATH: April 19 1967 | 11:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Cecil C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): SYKESVILLE 56-00

D. STREET ADDRESS (If rural, give location): Route #4 Box 403

5. SEX: FEMALE 6. RACE: WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: 12-25-24 9. AGE (In years last birthday): 42 If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSE 10B. KIND OF BUSINESS OR INDUSTRY: Hospital 11. BIRTHPLACE (State or foreign country): MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HUBERT H. HARKER 14. MOTHER'S MAIDEN NAME: ELIZABETH RUFF

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: ? 17. INFORMANT: LOUIS A. DE MONTE (HUSBAND) ADDRESS: SAME

MEDICAL CERTIFICATION

1B. 232 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebral Tumor (extensive)

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4-3 1967 to 4-10 1967, that (I) (~~we~~) last saw the deceased alive on 4-10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William P. Benson, Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 4-11-67

23C. PHYSICIAN'S NAME (Type): WILLIAM P. BENSON, JR. M.D. 23D. ADDRESS: 3506 N. CALVERT

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4-13-67 24C. NAME of CEMETERY or CREMATORY: Wards Chapel Cemetery 24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Harry W. Haight ADDRESS: Sykesville, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3634 Registered No. 67 3634

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LILLIAN THOMPSON

2. DATE AND HOUR OF DEATH 4/12/67 5⁰⁶ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-05

D. STREET ADDRESS (If rural, give location) 1520 HAZEL ST

5. SEX F

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow

8. DATE OF BIRTH Jan. 4, 1889

9. AGE (In years last birthday) 78

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME David Robertson

14. MOTHER'S MAIDEN NAME Sarah Zepp

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Robert Thompson ADDRESS 219 Maple Ave

MEDICAL CERTIFICATION

I B. 199.2 I 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PULMONARY INSUFFICIENCY — 2 days

DUE TO

(B) METASTATIC TUMOR primary unknown site — 3 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 4 yrs

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) ~~Yes~~ No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~9/64~~ 1964 to 4/12 1967, that (I) (we) last saw ~~the deceased~~ alive on 4/12/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Robert M. Hamilton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 4/12/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 4 15 67

24C. NAME of CEMETERY or CREMATORY Cedar Hill

24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md

25A. DATE REC'D BY HEALTH DEPT. APR 14 1967

25B. NAME OF REGISTRAR Robert E. Farley M.D.

25C. FUNERAL DIRECTOR Mc Cully ADDRESS 130 E. Fort Ave.

VS 150-REV. 1/1/65

0 3 6 7 2

SAB-48-99-06

S-616 67 3635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 3635

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM SCARBOROUGH

2. DATE AND HOUR OF DEATH: 4-11-67 10:35 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balt. City Hospitals 4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Harford

C. CITY OR TOWN (If outside city limits, write RURAL and give township): STREET 62-00 21154

D. STREET ADDRESS (If rural, give location): RT 2 P.O. Box 113

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12-30-07

9. AGE (In years last birthday): 59

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Munitions handler

10B. KIND OF BUSINESS OR INDUSTRY: Civil service

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lawrence Scarborough

14. MOTHER'S MAIDEN NAME: Lucy Chamberlain

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-24-4735

17. INFORMANT: Records: BCH-4940 Eastern Avenue ADDRESS: 21224

MEDICAL CERTIFICATION

1B. 3 3 3 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cardiorespiratory Arrest

DUE TO

(B) Posterior Fossa Mass.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-1-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Aqueduct Obstruction

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-1- 19 67 to 4-11- 19 67, that (I) (we) last saw the deceased alive on 4-11- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles Beckman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-11-1967

23C. PHYSICIAN'S NAME (Type): Charles Beckman M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-14-67

24C. NAME of CEMETERY or CREMATORY: Emory Methodist

24D. LOCATION (City, town, or county) (State): Street, Harford Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: John H. Harkins

ADDRESS: Delta, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-04-13 GG 1J-520 67 3636

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3636

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Marie Joynes

2. DATE AND HOUR OF DEATH: 8:40 A.M. 4-11-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE 21224, MARYLAND

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 7-03

D. STREET ADDRESS (If rural, give location): 718 N. Madeira Street 21205

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 3-1-1897

9. AGE (In years last birthday): 70

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Kress

14. MOTHER'S MAIDEN NAME: Mary Schrifer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-12-6342

17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue

ADDRESS: #21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Left acut subdural hematoma

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

E900.0

CERTIFICATION APPROVED BY: Sumio Uematsu M.D. CHIEF OR ASST. MEDICAL EXAMINER. 4-21-67

19A. DATE OF OPERATION: 4/9-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: left subdural hematoma

20A. AUTOPSY (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 3016 Lough St. Balt. Md

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): out side of house, fell from 2nd step.

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 8 (Year) 67 (Hour) 11pm

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? Fell from 2nd step of stairs.

22. I certify that (I) (this hospital) attended the deceased from 4/8 1967 to 4/11 1967, that (I) (we) last saw the deceased alive on April 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sumio Uematsu M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/11-67

23C. PHYSICIAN'S NAME (Type): Dr. Sumio Uematsu M.D.

23D. ADDRESS: 4940 Eastern Avenue Baltimore 21224, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 14 1967

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Philip E. Grach

ADDRESS: 1211 Chesaco Ave.

VS 150-REV. 1/1/65

N 854,2

H-506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3637 Registered No. 67 3637

M.E. CASE NO. MILLARD L. HINE

1. NAME OF DECEASED (Type or Print): Hine Millard L.

2. DATE AND HOUR OF DEATH: 4-12-67 | 3 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Charles General Hosp 49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1-01
D. STREET ADDRESS (If rural, give location): 716 Potomac (South) St. 21224

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: July 2, 1907
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Maker
10B. KIND OF BUSINESS OR INDUSTRY: Renninburg Co
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: John Hine
14. MOTHER'S MAIDEN NAME: Carolyn Ranck

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 181-05-9056
17. INFORMANT: Mrs. Marie Hine ADDRESS: 716 S. Potomac Street

MEDICAL CERTIFICATION

1B. 1 3 4 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Terminal ca of rectum.
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 4-12 1967 to 4-12 1967 that I (we) last saw the deceased alive on 3-PM 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) view the body after death.

23A. SIGNATURE: Carmela Stella M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-12-67
23C. PHYSICIAN'S NAME (Type): CARMELA STELLA M.D.
23D. ADDRESS: 715 N. Charles - Balto

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-15-1967
24C. NAME of CEMETERY or CREMATORY: Meadowridge Memorial Park
24D. LOCATION (City, town, or county) (State): Howard County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 1901-07 Eastern Ave.

VS 150-REV. 11/65

3 6 3 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3638 Registered No. 67 3638

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles Fred Simcoe

2. DATE AND HOUR OF DEATH: 4/10/67 5:15 P.M.

CERTIFICATE AMENDED

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital 5-10-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 15-06
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~2005 Dennison St.~~ Baltimore 21216
D. STREET ADDRESS (If rural, give location): 2005 Dennison St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	White	Single	1/18/~~1905~~ 1906	62 61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Paper Hanger	Self Employed	Parkton, Balt. Co. Md.	U.S.A.

13. FATHER'S NAME: Frank Simcoe

14. MOTHER'S MAIDEN NAME: Emma McCulloh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Alva Duvall Sr. ADDRESS: 6306 Frederick Rd. 21228

MEDICAL CERTIFICATION

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	
(A) Gastro-Intestinal Hemorrhage	Immediate
DUE TO (B) Cirrhosis of Liver	Many Months
DUE TO (C) Chronic Alcoholism	" "
ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ✓	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0 NONE		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN. 4 1967 to April 1, 1967, that (I) (we) last saw the deceased alive on April 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank N. Ogden M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 12, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Frank N. Ogden M.D.

23D. ADDRESS: 2701 N. Calvert St. Balt., Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/13/67	Pine Grove Cemetery	Rayville, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 14 1967	R. C. & E. Fox	Loring Byers	8728 Liberty Rd. Randallstown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1
C-652

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3639 Registered No. 67 3639

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES CORNISH

2. DATE AND HOUR PRONOUNCED DEAD: April 11, 1967 11:05 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 570 Wilson Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: Jan 10 1915
9. AGE (In years last birthday): 52
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-03-0789
17. INFORMANT: Margaret DeMinds ADDRESS: 1200 Argyle Ave

MEDICAL CERTIFICATION

18. 443X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral Hemorrhage (Pons)
DUE TO
(B) Hypertensive Cardiovascular Disease.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/15/1967
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
23D. LOCATION (City, town, or county) (State): Balto. Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
24B. NAME OF REGISTRAR: Robert E. Farber, M.D.
24C. FUNERAL DIRECTOR: Earl Gilmore ADDRESS: 1827 W. North Ave

VS 151-REV. 1/1/65

1967 00 03647

M-602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3640 Registered No. 67 3640

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LUCIUS L. A. MOORE SR.

2. DATE AND HOUR OF DEATH: 4/12/67 1:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1547 SHEFFIELD ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2738

D. STREET ADDRESS (If rural, give location): 1547 SHEFFIELD ROAD

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	5/13/97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CLERK	RETIRED	NORTH CAROLINA	U.S.A.

13. FATHER'S NAME: THOMAS MOORE

14. MOTHER'S MAIDEN NAME: EDNA LINDSAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 240-30-0816

17. INFORMANT: ETHEL H. MOORE ADDRESS: 1547 SHEFFIELD RD

MEDICAL CERTIFICATION

1B. 150X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Squamous Cell Carcinoma Oesophagus — 8 Mos

DUE TO

(B) Cerebral Metastasis — 2 mos

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this XXXXXX) attended the deceased from Oct. 5 19 66 to April 12 19 67, that (I) (we) last saw the deceased alive on April 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: T N Wilson M.D. Attending Phys. X ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 12, 1967

23C. PHYSICIAN'S NAME (Type): Dr. T. N. Wilson M.D.

23D. ADDRESS: 617 W. 40th Street

24A. BURIAL CREMATION, REMOVAL (Specify): CREMATION

24B. DATE: 4/13/67

24C. NAME of CEMETERY or CREMATORY: GREENMOUNT CREMATORY

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE RECEIVED BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Robert E. Altenburg Funeral Home, INC ADDRESS: 6009 HARFORD RD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 6 4 0

E. 2401

BIRTH NO. 67 3641

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3641

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): EDNA MAE EASLY

2. DATE AND HOUR OF DEATH: April 11, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1046 Harford Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1046 Harford Ave

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2/12/01
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Hampton, Virginia
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Albert Harris
14. MOTHER'S MAIDEN NAME: Lucy
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Louise Easly 1046 Harford Ave ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. 443X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ~~DUE TO~~ Hypertensive Cardio. Disease — 6-7 years
(B) DUE TO Dissecting.
(C) Congestive Heart failure.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar 1959 to Apr 1967, that (I) (we) last saw the deceased alive on 10 Apr 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Simon H Carter M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 13 April
23C. PHYSICIAN'S NAME (Type): Simon H. Carter, Jr. M.D.
23D. ADDRESS: 4215 Park Heights Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Farkas M.A.
25C. FUNERAL DIRECTOR: Adolphus Halstead 1206 W North Ave ADDRESS

VS 150-REV. 1/1/65

67 0 0 0 3 6 4 2

5 5361

BIRTH NO. 67 3642

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3642

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SAUNDERS, ARDELLA

2. DATE AND HOUR OF DEATH: 11 APRIL 67 9:40 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 17-03
D. STREET ADDRESS (If rural, give location): 702 DOLPHIN STREET #17

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 1888
9. AGE (In years last birthday): 79
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): CUMBERLAND COUNTY, VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HAMPTON
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: BROTHER — ADDRESS: 702 DOLPHIN ST, BALTIMORE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DOA

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. → (C) CERVICAL CARCINOMA

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11 APRIL 19 67 to 11 APRIL 19 67, that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Stapleton, Jr M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 11 APRIL 67
23C. PHYSICIAN'S NAME (Type): SIDNEY STAPLETON, JR M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/15/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetry
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Foley, M.D.
25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

W-3081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3643 Registered No. 67 3643

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): (Lloyd) Lloyd Wood

2. DATE AND HOUR OF DEATH: April 12, 1967 3:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17-02 D. STREET ADDRESS (If rural, give location): 595 Oxford street

5. SEX: M 6. RACE: C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH: Sept. 2, 1886 9. AGE (In years last birthday): 70 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country): Virginia 12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Sam Wood 14. MOTHER'S MAIDEN NAME: Birdie Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT: Medical Record ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH: (A) Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: March 23, 1967 to April 12, 1967

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO: (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: April 4, 1967 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 23 19 67 to April 12 19 67, that (I) (we) last saw the deceased alive on April 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Youngsik Moon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: April 12 1967

23C. PHYSICIAN'S NAME (Type): Youngsik Moon M.D. 23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/14/67 24C. NAME of CEMETERY or CREMATORY: National Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1967 0 0 3 6 4 1

L-000 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3644 Registered No. 67 3644

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Irene Lee

2. DATE AND HOUR OF DEATH: 4-13-67 | 4:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc. Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 707 Gold Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last bir day): 72
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Maron Lee (D) ADDRESS: 2244 Linden Ave.

MEDICAL CERTIFICATION

18. E916.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiopulmonary arrest.
DUE TO
(B) Second degree burns
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: [signature] M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☒
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 707 Gold St. 15-01
21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour): 4-3-67 6:40 PM
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR? Clothing caught fire while subject was cooking meal

22. I certify that (I) (this hospital) attended the deceased from 4-3-67 19 to 4-13-67 19, that (I) (we) last saw the deceased alive on 4-13-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lizarazo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-13-67
23C. PHYSICIAN'S NAME (Type): LIZARAZO M.D.
23D. ADDRESS: 1514 Division Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 17 67
24C. NAME of CEMETERY or CREMATORY: Arbutus M. Park
24D. LOCATION (City, town, or county): Balto (State): Md

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR: V. Brooks Ranggold
ADDRESS: 1463 N. Carey St

VS 150-REV. 1/1/65

H-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3645 Registered No. 67 3645

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edna Hunt

2. DATE AND HOUR OF DEATH: April 12, 1967 | 8:30p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Montebello Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Anne Arundel Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Severna 52-00
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 11-29-1907
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isiah Summerville
14. MOTHER'S MAIDEN NAME: Louise Jackson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hospital Chart
ADDRESS:

MEDICAL CERTIFICATION

18. 600.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Chronic Pyelonephritis — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 19 1967 to April 12 1967, that (I) (we) last saw the deceased alive on April 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar J. Pellegrino M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: April 12/67
23C. PHYSICIAN'S NAME (Type): Cesar J. Pellegrino M.D.
23D. ADDRESS: Montebello State Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-16-67
24C. NAME of CEMETERY or CREMATORY: Carpenter Hill Gardens
24D. LOCATION (City, town, or county) (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: William Reese Hunt
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M. 340 1

BIRTH NO. 67 3646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 827 67 3646

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Isaiah Medley

2. DATE AND HOUR OF DEATH: 4-12-67 4:45 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): George Washington Carver Nursing Home (607 Penna ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: A. A. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Gainsville Md. 52-00
D. STREET ADDRESS (If rural, give location): Galesville

5. SEX: MALE
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5-29-16
9. AGE (In years last birthday): 50 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gainsville Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Francis Medley
14. MOTHER'S MAIDEN NAME: Rosie Dent

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): unknown
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-05-0015A
17. INFORMANT: Chart
ADDRESS: 607 Pennsylvania Ave.

MEDICAL CERTIFICATION

18. 026 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Atrophy Contined — Unk
DUE TO
(B) Brain Syndrome — Unk
DUE TO
(C) Neurosyphilis Seizures — since 1964 approx.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/29 1967 to 4/12 1967, that (I) (we) last saw the deceased alive on 4/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: E. E. Hals M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/12/67
23C. PHYSICIAN'S NAME (Type): E. E. Hals M.D.
23D. ADDRESS: 3715 Liberty Heights

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-16-67
24C. NAME OF CEMETERY or CREMATORY: Ebenezer
24D. LOCATION (City, town, or county) (State): Galesville Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: William Reese
ADDRESS: Annapolis Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-65B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3647 Registered No. 67 3647

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mr. Fernandez, Willie M.

2. DATE AND HOUR OF DEATH: 4/12/67 | 9:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital 34 2025 West Fayette 23

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: 119 S. Conkling St.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): Md 26-08

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 10/13/84
9. AGE (In years last birthday): 83
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Continental Can Co
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Fernandez
14. MOTHER'S MAIDEN NAME: Komenski
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp't Records ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive heart failure
DUE TO
(B) Hypertensive arteriosclerotic heart
DUE TO cardiovascular disease
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Tuberculosis.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 11 1967 to April 12 1967, that (I) (we) last saw the deceased alive on April 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A M. Ghilardi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/12/67
23C. PHYSICIAN'S NAME (Type): Abdolhamid Ghilardi M.D.
23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apr. 14
24C. NAME of CEMETERY or CREMATORY: Gardens of Faith
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Fankhauser
25C. FUNERAL DIRECTOR: Joseph Zannino - Conkling & Hough per E.S. ADDRESS:

VS 150-REV. 1/1/65

C-612

BIRTH NO. 67 3648

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3648

1. NAME OF DECEASED (Type or Print): David Byers Carbaugh

2. DATE AND HOUR OF DEATH: April 11, 1967 6:50 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital 3100 Wyman Park Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Pa.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): York

V-35

D. STREET ADDRESS (If rural, give location): 1323 S. George Street

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Div.

8. DATE OF BIRTH: 7/13/36

9. AGE (In years last birthday): 30

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Driver

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bruce Carbaugh

14. MOTHER'S MAIDEN NAME: Cubie Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes

(If yes, give war or dates of service): USA 1958-1960

16. SOCIAL SECURITY NO.: 176-26-0299

17. INFORMANT: Records- US PHS Hospital, Balto, Md.

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 178 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic embryonal cell carcinoma lungs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: Months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 7 66 to Apr. 11 19 67, that (I)/(we) last saw the deceased alive on Apr. 11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael E. Pelczar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): Michael E. Pelcsar, SA Surgeon (R) M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/14/67

24C. NAME of CEMETERY or CREMATORY: Prospect Hill Cemetery

24D. LOCATION (City, town, or county) (State): York co. Pa.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.

ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

1

H-155

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3649 Registered No. 67 3649

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLARA HOFFMAN

2. DATE AND HOUR PRONOUNCED DEAD: April 11, 1967 1:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 35 CHURCH HOME & HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-04

D. STREET ADDRESS (If rural, give location): 1928 E. Fairmount Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: April 8, 1907

9. AGE (In years last birthday): ~~51~~ 60

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10B. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Harvey

14. MOTHER'S MAIDEN NAME: Clara Adeline Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-26-9393

17. INFORMANT: Ralph De Baufre ADDRESS: 4102 8 th St. 21215

MEDICAL CERTIFICATION

18. 581.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty alteration of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Partial

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-11-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/14/67

23C. NAME of CEMETERY or CREMATORY: Prospect Hill Cm.

23D. LOCATION (City, town, or county) (State): Towson, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St Paul St.

VS 151-REV. 1/1/65

1967 0003657

5-526

BIRTH NO. 67 3650

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3650

1. NAME OF DECEASED (Type or Print): PEARL SINGER

2. DATE AND HOUR OF DEATH: XXX 4/12/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP.

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-18
D. STREET ADDRESS (If rural, give location): 5215 LINDEN HEIGHTS AVE.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 10-4-14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: XXXXXX William Harris
14. MOTHER'S MAIDEN NAME: — Nettie Childress

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 239-24-1382
17. INFORMANT: HOSPITAL CHART. ADDRESS:

MEDICAL CERTIFICATION

1B. 38.1

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	INTERVAL BETWEEN ONSET AND DEATH
(A) HEPATIC COMA	12 HRS
DUE TO (B) GI BLEED	24 HRS
DUE TO (C) PEPTIC ULCER	?
DUE TO (D) LAENNEC'S CIRRHOSIS	5 YRS
DUE TO (C) CHRONIC ALCOHOLISM	27 YRS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OLIGURIA

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 4-11- 1967 to 4-12 1967, that (I) (we) last saw the deceased alive on 4-12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alvin Schachter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-12-67
23C. PHYSICIAN'S NAME (Type): ALVIN SCHACHTER M.D.
23D. ADDRESS: SINAI HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Catonsville, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Farkas MD
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. Baltimore, Md. 21202 ADDRESS:

VS 150-REV. 1/1/65

1967 0 0 3658

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 3651

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3651

1. NAME OF DECEASED (Type or Print): SADIE R. SPANGLER

2. DATE AND HOUR PRONOUNCED DEAD: April 12. 1967 11:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1941 Harlem Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04

D. STREET ADDRESS (If rural, give location): 1941 Harlem Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3/19/92

9. AGE (In years last birthday): 75 ~~XXX~~

If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Dell

14. MOTHER'S MAIDEN NAME: Florence Crout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: ~~XXX~~ Charles H. Spangler ADDRESS: 533 Oakland Ave.

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/12/67

23C. NAME of CEMETERY or CREMATORY: Baltimore, ~~M~~ Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St. Paul St.

VS 151-REV. 1/1/65

1967 0003659

T-620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3652

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3652

1. NAME OF DECEASED (Type or Print): NORRIS SALEM TRACEY

2. DATE AND HOUR OF DEATH: April 10, 1967 | 8:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 233 E. University Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 233 E. University Parkway 21218

12-02

00

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Oct. 30, 1885	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Telegraph Operator	Pennsylvania Railroad	Parkton, Maryland	U.S.A.

13. FATHER'S NAME: Edward T. Tracey

14. MOTHER'S MAIDEN NAME: Laura Morris

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 717-07-7898

17. INFORMANT: Mrs. Esther D. Tracey
ADDRESS: 233 E. University Pkwy

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 451X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO

(B) Aneurysm of abdominal aorta — 4 yrs.

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Oct. 13, 1966 to April 10, 1967, that (I) (~~we~~) last saw the deceased alive on April 6, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Apr. 12, 1967

23C. PHYSICIAN'S NAME (Type): LLoyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Ave.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	4-14-67	Moreland Memorial Park	Parkville	Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc.
ADDRESS: 1217 St. Paul Street

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 6 6 0

1
E-400

BIRTH NO. 67 3653

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3653

1. NAME OF DECEASED (Type or Print): ROY EL

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 2:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-03

D. STREET ADDRESS (If rural, give location): 813 N. Mount Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Separated	9/19/26	40				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Trucking Co	Baltimore Md	U S A

13. FATHER'S NAME: Nathaniel

14. MOTHER'S MAIDEN NAME: Pearl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Chart ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E976X

(A) Gunshot Wound of Head.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): House

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 804 N. Fulton Avenue 16-03

21D. TIME OF INJURY (APPROX.) (Month)	(Day)	(Year)	(Hour)	21E. INJURY OCCURRED WHILE AT WORK [ ]	NOT WHILE AT WORK [X]	21F. HOW DID INJURY OCCUR?
4	12	'67	P m.			Shot self.

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/17/67	Mt AUBURN Cemetry	Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 14 1967	Robert E. Falkenhan	Adolphus Halstead	1206 W North Ave

VS 151-REV. 1/1/65

N 856,476 / 0003661

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G-450

67 3654

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3654

1. NAME OF DECEASED (Type or Print): LEROY GREEN

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 6:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4021 Edgewood Road

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

15-11

D. STREET ADDRESS (If rural, give location): 4021 Edgewood Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months, Days	If Under 24 Hrs. Hours, Min.
Male	Negro	Married	March 3, 1924	43		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waiter	Hollander's Rest.	Baltimore, Md	U.S.A

13. FATHER'S NAME: D. Roy Green

14. MOTHER'S MAIDEN NAME: Aurelia Payne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW-II	219-18-5654	Mrs. Gertrude Green	4021 Edgewood Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	4/17/67	Baltimore National Cem.	Baltimore,	Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 14 1967	Robert E. Farley, M.D.	Herbert E. Nutter	3035 W. North Ave

VS 151-REV. 1/1/65

9 9 7 0 0 0 3 6 6 2

M-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3655 Registered No. 67 3655

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles W. Moorman, Sr.

2. DATE AND HOUR OF DEATH: April 14, 1967 | 5 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3224 Evergreen Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-44

D. STREET ADDRESS (If rural, give location): 3224 Evergreen Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 5-18-1906

9. AGE (In years last birthday): 60

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vending Machines

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles W. Moorman

14. MOTHER'S MAIDEN NAME: Sallie E. Berry

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217015283

17. INFORMANT: Mrs Louise S. Moorman

ADDRESS: same

MEDICAL CERTIFICATION

18. I 163 X 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Metastatic cancer — 7 mos

DUE TO

(B) Cancer of lung — 12 mos

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary artery dis.; diabetes

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Sept. 1952 to April 14 1967, that (I) (~~we~~) last saw the deceased alive on April 12 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Donald Jandorf M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-14-67

23C. PHYSICIAN'S NAME (Type): RDonald Jandorf M.D.

23D. ADDRESS: 6077 Hartford Rd

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 4-17-67

24C. NAME of CEMETERY or CREMATORY: Moreland Mem. Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahlman

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc

ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

1967 0 0 3 6 6 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3656 Registered No. 67 3656

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Timothy Joseph McAuliffe

2. DATE AND HOUR OF DEATH: April 13, 1967 2:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1001 E. Belvedere Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-48

D. STREET ADDRESS (If rural, give location): 1001 E. Belvedere Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 10-24-1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Guard

10B. KIND OF BUSINESS OR INDUSTRY: Armo Steel Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dennis McAuliffe

14. MOTHER'S MAIDEN NAME: Ellen T. Fitzgerald

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Mary McAuliffe

ADDRESS: same

MEDICAL CERTIFICATION

18. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Coronary Thrombosis

DUE TO

(B) Hypertension

DUE TO

(C) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 9-21 1967 to April 13 1967, that (I) (~~we~~) last saw the deceased alive on April 13 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Laurence C. Posk M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): LAURENCE C. POSK M.D.

23D. ADDRESS: 6805 York Rd - Baltimore 21212 Md

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 4-17-67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Tokuyama

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

1967 0 0 3 6 6 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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T-260

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3657 Registered No. 67 3657

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ERNEST J. TUCKER

2. DATE AND HOUR PRONOUNCED DEAD: April 10, 1967 10:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1830 Rutland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1830 Rutland Avenue

8-05

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	8-10-1903	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tractor operator	Steel Co.	Clover, Va.	U.S.A.

13. FATHER'S NAME: Joseph Tucker

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-07-1380

17. INFORMANT: Geneva Caldwell R. 9 Box 204 Pasedena, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 422.1

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-11-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-15-67	Mt. Calvary Cemetery	Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 14 1967	Robert E. Falkenhan	Randolph J. Codlick	2431 E. Oliver St.

VS 151-REV. 1/1/65

9 6 7 0 0 3 6 5 7

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4-520
M-650

BIRTH NO. 67 3658

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3658

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANGELO HINES MORENO

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 11:34 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-85
D. STREET ADDRESS (If rural, give location): 1717 Cliftview Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: March 20, 1951
9. AGE (In years last birthday): 16
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired): Child
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Caraphas Moreno
14. MOTHER'S MAIDEN NAME: Pearl Hines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Pearl H. Moreno
ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 18. E981X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot Wound of Chest.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 8-06 Front of 1642 W. Washington Street

21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 12 (Year) '67 (Hour) P m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Shot in chest.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-17-67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Choy O. Wilson
ADDRESS: 1000 Brantley Ln

VS 151-REV. 1/1/65

N8-13,4 3666

48-33-52 DH 1 5-530 67 3659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3659

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph Smith (Joseph Smith)

2. DATE AND HOUR OF DEATH: 4/11/67 | 6 05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore, Maryland #21224

Baltimore City Hospital 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 10-01

D. STREET ADDRESS (If rural, give location): 323 E Biddle ST. #21213

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): never married

8. DATE OF DATE OF BIRTH: 4/16/03

9. AGE (In years last birthday): 64 + 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (Laborer)

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): ~~South Carolina~~ North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Smith (Charles Smith)

14. MOTHER'S MAIDEN NAME: Laura Davis (Laura Davis)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 440-10-4482

17. INFORMANT: Ollie Wilson ADDRESS: Same as above

MEDICAL CERTIFICATION

18. 450.0 + 002.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~DUE TO~~ Arteriosclerosis, generalized — 15 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) ~~DUE TO~~ pulmonary Tuberculosis — 5 mo

(C) (?) bacterial pneumonia — 3 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Probable renal failure — months

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from — 1958 to April 11 1967, that (I) ~~(we)~~ last saw the deceased alive on 4/11 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: David Pierce Curtiss Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): David P. Curtiss Jr. David Pierce Curtiss Jr. M.D.

23D. ADDRESS: Balto City Hospital 4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-15-67

24C. NAME OF CEMETERY or CREMATORY: Mt Calvary Cem

24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Cloyd Wilson ADDRESS: 1000 Brambleton

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-653

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3660 Registered No. 67 3660

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MR. FULTON GRANT

2. DATE AND HOUR OF DEATH: APRIL 12, 1967 650 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIA HOSPITAL 44

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 12-04

D. STREET ADDRESS (If rural, give location): 2000 BARCLAY ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	COLORED	DIVORCED	09-13-10	56.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER		SOUTH CAROLINA	AMERICAN

13. FATHER'S NAME: (?) Boyd Grazze

14. MOTHER'S MAIDEN NAME: CORINNE Stevenson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): N (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Viola Gregg ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Intracerebral hemorrhage

DUE TO

(B) Aspiration of gastric contents

DUE TO

(C) with hemorrhagic congestion of lungs

A. Hypolito, M.D.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/10/ 1967 to 4/12 1967, that (I) (we) last saw the deceased alive on 4/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjofur Bjornsson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-15-67	Mt Auburn Cem	Balto Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 14 1967	Robert E. Farley M.D.	Clay O Wilson	1200 Brentley Ave

VS 150-REV. 1/1/65

3660

B-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3661 Registered No. 67 3661

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Brown Amos

2. DATE AND HOUR OF DEATH: 12 April 67 12:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 701 Cumberland St

15-01

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5. SEX: M 6. RACE: C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): 8. DATE OF BIRTH: 12/13/00 9. AGE (In years last birthday): 66 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): USA N.C. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rufus Brown 14. MOTHER'S MAIDEN NAME: Lola Rogers

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown): Unk (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: 240-09-7033A 17. INFORMANT: Cousin Agnes Brown ADDRESS: Same

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory Arrest — 10 minutes

DUE TO

(B) Status Epileptiens

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Tracheostomy 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Respiration 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/5/67 19 to 4/12/67 19, that (I) (we) last saw the deceased alive on 4/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John Wm Eckhardt M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 12 April 67

23C. PHYSICIAN'S NAME (Type): John Wm Eckhardt M.D. 23D. ADDRESS: Univ Hospital Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/15/67 24C. NAME of CEMETERY or CREMATORY: Mt. Auburn 24D. LOCATION (City, town, or county): Baltimore (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: Arlington Shelley ADDRESS: 1727 N. Monroe St.

VS 150-REV. 1/1/65

1967 0 0 3 6 6 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3662 Registered No. 67 3662

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Hallie Russell

2. DATE AND HOUR OF DEATH: April 11, 1967 | 11:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 39 Provident Hospital Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3114 Belmont Avenue

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Jan. 27, 1923
9. AGE (In years last birthday): 44
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Garland Allen
14. MOTHER'S MAIDEN NAME: Marie Carter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 220-16-6669
17. INFORMANT: George Russell ADDRESS: 3114 Belmont Avenue

MEDICAL CERTIFICATION

18. 170 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Hemoperitoneum from
DUE TO ruptured liver;
(B) Infiltrative Carcinoma
DUE TO
(C) Carcinoma of breast

INTERVAL BETWEEN ONSET AND DEATH: 4 1/2 hrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4-7- 1967 to 4-11- 1967, that (I) (~~we~~) last saw the deceased alive on 4-11- 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: E. C. Clay M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-14-67
23C. PHYSICIAN'S NAME (Type): EARL C. CLAY M.D.
23D. ADDRESS: 3405 GARRISON BLVD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-17-67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. APR 14 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Arlington S. Phillips ADDRESS: 1727 N. Monroe St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3663 Registered No. 67 3663

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SPENCER, RONALD

2. DATE AND HOUR OF DEATH: 4/12/67 2 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

1607

D. STREET ADDRESS (If rural, give location): 1209 Oakhurst Pl.

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 3-14-41

9. AGE (In years last birthday): 26

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kennecott Refining Co

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Spencer

14. MOTHER'S MAIDEN NAME: Beatrice Wood

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-38-5942

17. INFORMANT: Beatrice Spencer

ADDRESS: 1219 Oakhurst Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 1561 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA LIVER

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes) or No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-6-67 19 to 4-12-19 67, that (I) (we) last saw the deceased alive on 4-12- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/15/67

24C. NAME of CEMETERY or CREMATORY: Carmel Mem. Pk.

24D. LOCATION (City, town, or county) (State): Laurel Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Phillips Funeral Home

ADDRESS: R. Hall

VS 150-REV. 1/1/65

1
G-100

67 3664

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3664

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SAMUEL F GEPPI

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 9:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 530 W. Mulberry Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 4/23/1914
9. AGE (In years last birthday): ~~54~~ 53
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed
10B. KIND OF BUSINESS OR INDUSTRY: Produce Business
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Geppi
14. MOTHER'S MAIDEN NAME: Pauline Tramontana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: 218-03-6481
17. INFORMANT: Mr. Anthony Geppi ADDRESS: Above

MEDICAL CERTIFICATION

18. 443 X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/17/67
23C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.
23D. LOCATION (City, town, or county) (State): 5501 Frederick Ave Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 14 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: John J. Cowan & Son Inc.
ADDRESS: 901 ~~St.~~ Hollins

VS 151-REV. 1/1/65

1967 0 0 3 6 7 2

23 Md. V

L-200

To Be Counter Signed by Pat. Co. Coroner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3665 — Registered No. 67 3665

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Leech, Hugh H. (Leech, Hugh H.)

2. DATE AND HOUR OF DEATH: 13 APR 1967 | 12:15 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hosp Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: USA 27 07 C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21234 D. STREET ADDRESS (If rural, give location): 2927 Berwick Ave.

5. SEX: M | 6. RACE: W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married | 8. DATE OF BIRTH: 08-11-81 | 9. AGE (In years last birthday): 85 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer-Mechanical | 10B. KIND OF BUSINESS OR INDUSTRY: — | 11. BIRTHPLACE (State or foreign country): Bohemia | 12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alexander Leech | 14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or date of service) | 16. SOCIAL SECURITY NO.: 220-05-5360 | 17. INFORMANT: Mrs Marie Leech | ADDRESS: same

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia (R)

(B) DUE TO: Carcinoma of Prostate Metastatic

(C) DUE TO: Fx Hip (R), Pathologic

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A), stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

NOT A MEDICAL EXAMINER'S CASE — CHIEF OR ASST. MEDICAL EXAMINER — M.D.

19A. DATE OF OPERATION: 2/15/67 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fx Hip (R) | 20A. AUTOPSY? (Yes or No): YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-28 1967 to 4-13 1967, that (I) (we) last saw the deceased alive on ____ 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ | 23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type): Michael S. Ryan M.D. | 23D. ADDRESS: Maryland Gen Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): burial | 24B. DATE: 4-17-67 | 24C. NAME of CEMETERY or CREMATORY: Moreland Mem. Park | 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 14 1967 | 25B. NAME OF REGISTRAR: Robert E. Faulkner M.D. | 25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc Baltimore, Md. | ADDRESS

VS 150-REV. 1/1/65 N 820967003623

SAB-48-07-70 1

C-125 67 3666

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3666

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Gibson, Anna B.

2. DATE AND HOUR OF DEATH: 4/11/67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224 — 31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — 9-07
D. STREET ADDRESS (If rural, give location): 1703 Homestead Street 21218

5. SEX: Female
6. RACE: Negro
7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify)): Widowed
8. DATE OF BIRTH: 12-25-1904
9. AGE (In years last birthday): 62
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Perry
14. MOTHER'S MAIDEN NAME: Alice Sherrod

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224 — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 171 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: urinary tract infect + septicemia — 1 wk.

(B) DUE TO: Stage 4 ca prob. of cervix — mos.

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: hx Hypertension; CVA-(R) hemiparesis + aphasia — 5 mos

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/15 1967 to 4/11 1967, that (I) (we) last saw the deceased alive on 4/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ann Louise Silver M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/11/67
23C. PHYSICIAN'S NAME (Type): Ann Louise Silver M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: BALTO. NATIONAL
24D. LOCATION (City, town, or county) (State): 5501 Frederick Ave

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Joseph G. Lockt. Jr. — ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/65

R-5001

BIRTH NO. 67 3667

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3667

1. NAME OF DECEASED (Type or Print): WILLIAM GEORGE RYAN

2. DATE AND HOUR OF DEATH: APRIL 12, 1967 | 2:00AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO., 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTO. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE

53.00

D. STREET ADDRESS (If rural, give location): 5 KENWOOD AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	CAUCASION	MARRIED	01/24/00	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
MARINE ENGINEER	ORE STEAMSHIP	SCOTLAND	~~UNKNOWN~~ U.S.A.

13. FATHER'S NAME: JOHN EDWARD RYAN DEC'D

14. MOTHER'S MAIDEN NAME: ANN ~~BELLANY~~ Ballany DED'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO.: 220-07-2500

17. INFORMANT: ST. AGNES RECORDS; WILKENS & CATON AVE

ADDRESS:

MEDICAL CERTIFICATION

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral Thrombosis

DUE TO

(B) ASCVD

DUE TO

(C) Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial Insufficiency

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 1 19 67 to APRIL 12 19 67, that (I) (we) last saw the deceased alive on APRIL 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George S. Patrick M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): GEORGE S. PATRICK M.D.

23D. ADDRESS: WILKENS & CATON AVES. BALTO. 29, MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-15-67	New Cathedral Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Fahrney	Howard H. Hubbard	4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

67 0 0 3 6 7 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-631

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-06862 67 3668

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3668 4

1. NAME OF DECEASED (Type or Print): Baby ~~of Louise~~ Garrett (Girl)

2. DATE AND HOUR OF DEATH: 4-1-67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 9-07

D. STREET ADDRESS (If rural, give location): 2537 Kirk Avenue

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 4-1-67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 45

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Garrett

14. MOTHER'S MAIDEN NAME: Edmonds

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Louise Garrett - mother ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 762.5

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity

DUE TO

(B) Massive pulmonary atelectasis, Bilateral

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1, 1967 to April 1, 1967, that (I) (we) last saw the deceased alive on April 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. Mercado M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-10-67

23C. PHYSICIAN'S NAME (Type): Manuel G. Mercado M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 4-12-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 150-REV. 1/1/65

C-16d

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3669 67-06868 — Registered No. 67 3669 4

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): G-1 Baby of ~~Christine~~ Cooper

2. DATE AND HOUR OF DEATH: 4-5-67 — 12:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc. 39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland — B. COUNTY: — C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 15-10 — D. STREET ADDRESS (If rural, give location): 3408 Oakfield Avenue

5. SEX: Female — 6. RACE: Negro — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single — 8. DATE OF BIRTH: 4-3-67 — 9. AGE (In years last birthday): — If Under 1 Yr. Months: Days: 2 — If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Baltimore, Maryland — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: — 14. MOTHER'S MAIDEN NAME: Cooper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: Christine Cooper- mother — ADDRESS: SAME

MEDICAL CERTIFICATION

18. 7735 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Prematurity

DUE TO

(B) Placa dysfunctn

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: } 12-24 hrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): ~~No~~ YES — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 3, 1967 to April 5, 1967, that (I) (we) last saw the deceased alive on April 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ — 23B. DATE SIGNED: 4-5-67

23C. PHYSICIAN'S NAME (Type): MANUEL G. MERCADO M.D. — 23D. ADDRESS: 1514 Division Street - Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): — 24B. DATE: 4-12-67 — 24C. NAME of CEMETERY or CREMATORY: — 24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967 — 25B. NAME OF REGISTRAR: [signature] — 25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD — ADDRESS:

VS 150-REV. 1/1/65

B-653 1

BIRTH NO. 67-05868 67 3670

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3670

1. NAME OF DECEASED (Type or Print): Girl Baby ~~of Jane~~ Brandon

2. DATE AND HOUR OF DEATH: 3-22-67 12:30 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: Provident Hospital, Inc.

(If not in hospital or institution, give street address or location)

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dundalk, 53-00

D. STREET ADDRESS (If rural, give location): 627 New Pittsburgh Avenue

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 3-22-67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 9 Min.: 20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Brandon

14. MOTHER'S MAIDEN NAME: Jane Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Jane Brandon

ADDRESS: SAME

MEDICAL CERTIFICATION

1B. 774X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Prematurity

DUE TO

(B) Resp. distress

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3-6 hrs.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cong. heart disease

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 22, 1967 to March 22, 1967, that (I) (we) last saw the deceased alive on March 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Manuel Mercado M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-5-67

23C. PHYSICIAN'S NAME (Type): MANUEL G. MERCADO M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 4-12-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMICAL MATERIAL
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR:

ADDRESS:

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

D-355

67-05765 67 3671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3671 Y

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Dedmon B

2. DATE AND HOUR OF DEATH: 3/19/67 9 30 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 15-13

D. STREET ADDRESS (If rural, give location): 2831 Boarman Ave

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: 3/18/67

9. AGE (In years last birthday): 10 hours

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 10 Min.: 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Sinai Hosp. Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Larry

14. MOTHER'S MAIDEN NAME: Toone ~~2831 Boarman Ave.~~

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 773.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 10 ½ hr

DUE TO

(B) Prematurity (760gm.)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11:05 pm 3/18 19 67 to 9 30 am 3/19 19 67. that (I) (we) last saw the deceased alive on 3/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John D. Johnson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ Assistant Resident

23B. DATE SIGNED: 3/19/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 4-13-67

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

ANATOMICAL BOARD OF MARYLAND

JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-62d

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-65733 67 3672

Registered No. 67 3672 4

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Boy (B)

2. DATE AND HOUR OF DEATH: 3/20/67 11:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Harford 62-00
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Baltimore~~ Fallston
D. STREET ADDRESS (If rural, give location): Route 2 Box 77 Lawson Rd

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 3/20/67
9. AGE (In years last birthday):
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.: 40

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John D. Brueck
14. MOTHER'S MAIDEN NAME: Ellen Brueck

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

I B. 773.51

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory Immaturity — 50 minutes
DUE TO
(B) Pre-maturity
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Sac of Baby "A" ruptured & cord prolapsed.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert M. Blum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 3/20/67
23C. PHYSICIAN'S NAME (Type): Robert M. Blum, M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: ADDRESS:

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-624

67-07235

BIRTH NO. 67 3673

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3673

1. NAME OF DECEASED (Type or Print): BABY Girl KARACOULAKIS ~~Karaclaski~~

2. DATE AND HOUR OF DEATH: 4/11/67 | 4:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42 BALTO, MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 53-00

D. STREET ADDRESS (If rural, give location): 1330 Forest Road Forrest

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 4/11/67

9. AGE (In years last birthday):

If Under 1 Yr. Months: Days: Hours: 12 Min.: 04

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ANTHONY KARACOULAKIS ~~Karaclaski~~

14. MOTHER'S MAIDEN NAME: Deborah Humin

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMATURITY (840 gms) — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4/11 1967 to 4/12 1967, that ~~(I)~~ (we) last saw the deceased alive on 4/12 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): Louis L. Fine, MD M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 4-13-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND

JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR:

ADDRESS:

MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-357

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-05764 67 3674

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3674 4

1. NAME OF DECEASED (Type or Print): Baby Girl Dedmon A

2. DATE AND HOUR OF DEATH: 3/19/67 1:28 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital 42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 15-13
D. STREET ADDRESS (If rural, give location): 2831 Boarman Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	N	—	3/18/67	14 hours			14	26

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Sinai Hospital, Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Larry

14. MOTHER'S MAIDEN NAME: Toone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: 2831 Boarman Ave. ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Insufficiency — 14 hr 26 min
DUE TO
(B) Prematurity (720 gm)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11:03 pm 3/18 19 67 to 1:28 pm 3/19 19 67, that (I) (we) last saw the deceased alive on 3/19 19 67 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John D. Johnson — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ — Assistant Resident

23B. DATE SIGNED: 3/19/67

23C. PHYSICIAN'S NAME (Type): M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 4-13-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Ruby B. E. Fabens

25C. FUNERAL DIRECTOR:

ADDRESS:

VS 150-REV. 1/1/65

S-6001

67-06958

BIRTH NO. 67 3675

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3675 4

1. NAME OF DECEASED (Type or Print): Baby Girl Shear "A"

2. DATE AND HOUR OF DEATH: 4-6-67 4:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY: Balto. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Randallstown MD 53-00

D. STREET ADDRESS (If rural, give location): 8418 Charton Rd

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 4-6-67

9. AGE (In years last birthday) | If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.: 55 min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Donald Shear

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MEDICAL CERTIFICATION

18. 776 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Immaturity

(B) DUE TO:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-6 19 67 to 19 , that (I) (we) last saw the deceased alive on 4-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Josephine G. Brunidor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-6-67

23C. PHYSICIAN'S NAME (Type): Josephine G. Brunidor M.D.

23D. ADDRESS: Sinai Hosp of Balto. MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE: 4-13-67

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fridgen

25C. FUNERAL DIRECTOR

ADDRESS

VS 150-REV. 1/1966

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-6001

67-069-59

BIRTH NO. 67 3676

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3676

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Girl Shear "B"

2. DATE AND HOUR OF DEATH: 4-6-67 7:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Randalls town 53-00
D. STREET ADDRESS (If rural, give location): 8418 Charlton Rd

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 4-6-67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 45 min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Donald Shear
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Immaturity
DUE TO
(B)
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-6 19 67 to 19 , that (I) (we) last saw the deceased alive on 4-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Josephine G. Brunidor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-6-67
23C. PHYSICIAN'S NAME (Type): Josephine Brunidor M.D.
23D. ADDRESS: Anatomy Dept. of Balto. MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY: JOHNS HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 150-REV. 1/1/65

K-65d

67 3677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3677 4

BIRTH NO. 67-07121

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY KERN

2. DATE AND HOUR OF DEATH: 4/3/67 4:45 a.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 2933 Guilford Ave.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): –
8. DATE OF BIRTH: 4/2/67
9. AGE (In years last birthday): If Under 1 Yr. Months Days; If Under 24 Hrs. Hours 5 Min. 15

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: JOHN MALLAIALIER
14. MOTHER'S MAIDEN NAME: SHARON KERN.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PREMATURITY – — 5 HR 15 MIN.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 4/2/ 19 67 to 4/3/67 19 , that (I) ~~(we)~~ last saw the deceased alive on 4/3/ 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: K. Shaw M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): KAILIE SHAW, M.D. K. SHAW.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 4-7-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Ralph E. Fabrum M.D.
25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 150-REV. 1/1/65

B-26

67-05496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3678 Registered No. 67 3678

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Booker

2. DATE AND HOUR OF DEATH: 3/20/67 12 10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY: X
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-32
D. STREET ADDRESS (If rural, give location): 809 Seagull Ave

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —
8. DATE OF BIRTH: 3/19/67
9. AGE (In years last birthday): —
If Under 1 Yr. Months: Days: Hours: 24 Min.: 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Rosedyn E. Booker
ADDRESS: same

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hosp. Chart

MEDICAL CERTIFICATION

18. 773.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Hyaline membrane disease — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.
DUE TO
(B) Prematurity (B.W. 1098 gm)
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 19 1967 to March 20 1967, that (I) (we) last saw the deceased alive on March 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Franklin D. Johnson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 3/20/67 2 15 pm.
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: University Hosp

24A. BURIAL CREMATION, REMOVAL (Specify)
24B. DATE: 4-13-67
24C. NAME of CEMETERY or CREMATORY
24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fogleman
25C. FUNERAL DIRECTOR
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3679 Registered No. 67 3679

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAGARRITY MILTON JOHN

2. DATE AND HOUR OF DEATH: 4·5·67 10,15 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 512 East 21st St

5. SEX: M
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5·17·00
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Milton John Magarrity
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 154X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of rectum c̄ Vesico-rectal fistula
DUE TO
(B) Pulmonary emboli in arterioles.
DUE TO
(C) Paralytic ileus
Aspiration of stomach content c̄ pneumonia

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 3·31·67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of rectum
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to APRIL 5 1967, that (I) (we) last saw the deceased alive on APRIL 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles E. Boring Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: APRIL 6, 1967
23C. PHYSICIAN'S NAME (Type): CHARLES E. BORING JR. MD. M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPTIAL

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 4-12-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: J. L. MORTUARY SERVICE - BCHD
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
K-425

67 3680

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3680

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VINCENT A. KULUCZNIK

2. DATE AND HOUR PRONOUNCED DEAD: March 26, 1967 2:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 92 Baltimore City Jail

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01

D. STREET ADDRESS (If rural, give location): 1603 E. Baltimore Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH:

9. AGE (In years last birthday): 61

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: March 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify):

23B. DATE: 4-6-67

23C. NAME of CEMETERY or CREMATORY:

23D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 151-REV. 1/1/65

1967 0003688

45-98-03TN 1 W-420

BIRTH NO. 67 3681

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3681

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Andrew Wallace

2. DATE AND HOUR OF DEATH: 3/24/67 11:15 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-09

D. STREET ADDRESS (If rural, give location): 4029 DUVAL AVENUE 21216

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 3-18-81

9. AGE (In years last birthday): 86

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: BCH: RECORDS

ADDRESS: 4940 EASTERN AVENUE 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovasc. Dis — INTERVAL BETWEEN ONSET AND DEATH: 20 yr

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 1/19/67 19 to 3/24 19 67, that (I) (we) last saw the deceased alive on 3/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William A. Emerson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 3/24/67

23C. PHYSICIAN'S NAME (Type): DR. WILLIAM A. EMERSON M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 4-13-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fairbrother

25C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD

ADDRESS:

VS 150-REV. 1/1/65

33-75-66 DH B-656

BIRTH NO. 67 3682

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3682

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): CHARLES BRENHART

2. DATE AND HOUR OF DEATH: 3-27-67 | 10:40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
31 4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 19-03
D. STREET ADDRESS (If rural, give location): 1400 McHENRY STREET #21223

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): ?
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): (67)
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-05-2713
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue Baltimore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulm. TBC — 6 mos
DUE TO
(B) Pulm. Embolus
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

002.1

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-13-67 19 67 to 3-27 19 67, that (I) (we) last saw the deceased alive on 3-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Richmon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 3-27
23C. PHYSICIAN'S NAME (Type): J. RICHMON M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. #21224

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 4-10-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State):

ANATOMY BOARD OF MARYLAND
JOHNS HOPKINS MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR:
ADDRESS:

MORTUARY SERVICE - BCHD

VS 150-REV. 1/1/65

1967 0 0 3 6 9 0

C-2301

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3683

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3683

1. NAME OF DECEASED (Type or Print): JOSEPH CASCHETTA

2. DATE AND HOUR OF DEATH: 4/13/67 8 30/P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Reisterstown 53-00
D. STREET ADDRESS (If rural, give location): Berrymans Lane

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: July 18 1898
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Huckster
10B. KIND OF BUSINESS OR INDUSTRY: Selling
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pasquale Caschetta
14. MOTHER'S MAIDEN NAME: Filomena Fischietti

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-05-0079
17. INFORMANT: Mrs A. E. Caschetta ADDRESS: Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

(A) CORONARY ARTERY DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 6 YRS
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4/13 1967 to 4/13 1967, that (I) (~~we~~) last saw the deceased alive on 4/13 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Raymond F. Caplan M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): RAYMOND F. CAPLAN M.D.
23D. ADDRESS: 1010 ST. PAUL ST. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: Garden of Faith
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: H. J. Eckhardt ADDRESS: Owings Mills, Md.

VS 150-REV. 1/1/65

R-30

BIRTH NO. 67 3684

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3684

1. NAME OF DECEASED (Type or Print): RUTH, MR. FRANCIS, S.,

2. DATE AND HOUR OF DEATH: 4-14-67 at 9 pm. | 9 00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 CHURCH HOME & HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-07

D. STREET ADDRESS (If rural, give location): 526 S. NEWKIRK ST. #21224.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 12-13-15

9. AGE (In years last birthday): 51

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY: CROWN, CORK + SEAL Co.

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: SYLVESTER RUTH

14. MOTHER'S MAIDEN NAME: NELLIE KIMMETT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: 218-01-9659

17. INFORMANT: CHURCH HOME & HOSP.

ADDRESS:

MEDICAL CERTIFICATION

I

1B. F221 I 002.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pacemaker, Acute Myocardial Infarction — 8 mo

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Pulmonary Emphysema, Pulmonary Tuberculosis, healed. } Yrs.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4. 10. 1967 to 4. 14. 1967, that (I) (we) last saw the deceased alive on 4. 14. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Francisco Baltazar, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR, JR. M.D.

23D. ADDRESS: CHURCH HOME & HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: HOLY REDEEMER CEM.

24D. LOCATION (City, town, or county) (State): 4430 BELAIR RD. BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Richard E. Fuhrman

25C. FUNERAL DIRECTOR: Charles L. Geiler

ADDRESS: 6224 EASTERN AVE. BALTO., 21224, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-420 1

BIRTH NO. 67 3685

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3685

1. NAME OF DECEASED (Type or Print): Palmer Pollock

2. DATE AND HOUR PRONOUNCED DEAD: April 15, 1967 12:38 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New Jersey
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montclair V-27
D. STREET ADDRESS (If rural, give location): 214 Park Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Single	Oct 29,1920	46				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant Marine		N.J.	USA

13. FATHER'S NAME: Robert Pollock

14. MOTHER'S MAIDEN NAME: Sarah Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E857X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Purulent peritonitis following
DUE TO blunt force injury of abdomen.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): ship

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): S.S. AUSTRALIA REEF Pier 3,Locust Point 24-21

21D. TIME OF INJURY (APPROX.) (Month) 3 (Day) 15 (Year) 67 (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? Tow line snapped and struck subject

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: April 15,1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/19/67

23C. NAME of CEMETERY or CREMATORY: Cedar Lawn Cem

23D. LOCATION (City, town, or county) (State): Patterson N.J.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: McCully F H

ADDRESS: 237 Patapsco Ave 21225

VS 151-REV. 1/1/65

N868 3 6 7 0 0 3 6 9 3

K-252 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3686

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3686

1. NAME OF DECEASED (Type or Print): (KUCHINSKY, VINCENT) Kuczinski-Kuczinsky

2. DATE AND HOUR OF DEATH: 4/14/67 11 30 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL Hosp 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE CITY 14-01
D. STREET ADDRESS (If rural, give location): BOLTON HILL NURSING HOME

5. SEX: M
6. RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 8-15-81
9. AGE (In years last birthday): 85
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): LITHUANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-03-8877
17. INFORMANT: Hospital Records,
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. 1B. E9021 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death) 15 4.67 (A) PNEMONIA. — 2 DAYS
DUE TO
(B) FRACTURED HIP — 5 DAYS
DUE TO
(C)

CERTIFICATION APPROVED BY
Wilmer H. Fink M.D.
CORONER OR ASST. MEDICAL EXAMINER

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD & SENILITY

19A. DATE OF OPERATION: 4-11-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: FRACTURED HIP
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): BOLTON HILL NURSING HOME
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): — 14-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4 11 67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR? FELL OUT OF BED

22. I certify that ~~I~~ (this hospital) attended the deceased from 4-9-67 19 to 4-14-67 19, that (~~I~~) (we) last saw the deceased alive on 4-14-67 19 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert M Beasley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): ROBERT M BEASLEY M.D.
23D. ADDRESS: Maryland Gen'l Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-18-1967
24C. NAME OF CEMETERY or CREMATORY: Most Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: Thomas J Kenny Inc 1600 Hollins St
ADDRESS:

VS 150-REV. 1/1/65 N 820 67 003694

W-325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3687 Registered No. 67 3687

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Viola K. Watkins

2. DATE AND HOUR OF DEATH: 4/12/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 708 Puritan St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 13-05
D. STREET ADDRESS (If rural, give location): 708 Puritan St.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/6/98
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Howard S. Watkins ADDRESS: 708 Puritan St.

MEDICAL CERTIFICATION

1B. 1567.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of ~~colon with metastasis~~ bile ducts & liver — Several mos.

DUE TO

also

(B) Congestive heart failure — Several mos.

(C) Hypertrophic arthritis — Several years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1966 to April 12, 1967, that (I) (we) last saw the deceased alive on April 11, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. [X] Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-14-67
23C. PHYSICIAN'S NAME (Type): E. Ellsworth Cook, Jr., M.D.
23D. ADDRESS: 2431 Maryland Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/15/67
24C. NAME of CEMETERY or CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Paul E. Chenoweth ADDRESS: 3617 Chestnut Ave.

VS 150-REV. 1/1/65

1967 00 0 3 6 9 E

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-400

67-07371

BIRTH NO. 67 3688

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 67 3688

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Wiley

2. DATE AND HOUR OF DEATH: 4/13/67 | 9 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto. Co. 63-00
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Maryland 21227
D. STREET ADDRESS (If rural, give location): 23 Melrose Ave.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 4/13/67
9. AGE (In years last birthday): If Under 1 Yr. Months | Days | Hours: 6 | Min.: 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: David Wiley
14. MOTHER'S MAIDEN NAME: Stephanie Spicer
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. 762.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Prematurity
DUE TO
(B) Respiratory
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/67
24C. NAME of CEMETERY or CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Boots Md

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Ralph E. Fairbanks
25C. FUNERAL DIRECTOR: Thomas J. Kenny
ADDRESS: 1600 Bolton St

VS 150-REV. 1/1/65

L-1001

67-08233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3689 Registered No. 67 3689

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Levi

2. DATE AND HOUR OF DEATH: 10 40 pm 4/13/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-D1
D. STREET ADDRESS (If rural, give location): 2025 W Fayette St.

5. SEX: Femal
6. RACE: C.
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 4.13.67
9. AGE (In years last birthday): ~~newborn~~
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.: 20

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT:
ADDRESS:

MEDICAL CERTIFICATION

18. 776X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO: Prematurity

(B) DUE TO:

(C):

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on 4 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Barkan M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4.13.67
23C. PHYSICIAN'S NAME (Type): Dr. Jacobs (clinic) M.D.
23D. ADDRESS: Bon-Secours hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/67
24C. NAME of CEMETERY or CREMATORY: St Peters Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT. APR 17 1967
25B. NAME OF REGISTRAR: Roberts L. Taylor M.D.
25C. FUNERAL DIRECTOR: Thomas H. Lynch
ADDRESS: 1600 Bolton St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-634

67-07798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3690 Registered No. 67 3690

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Bradley

2. DATE AND HOUR OF DEATH: 4-12-67 | 7:45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-08

D. STREET ADDRESS (If rural, give location): 2225 Haven St.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 4-10-67

9. AGE (In years last birthday):

If Under 1 Yr. Months: Days: 1 If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Bradley

14. MOTHER'S MAIDEN NAME: Sharon Auersa.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. C. Bradley

ADDRESS: 2225 Haven St.

MEDICAL CERTIFICATION

18. 226X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 4-10 1967 to 4-12 1967, that (I) (we) last saw the deceased alive on 4-12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Perry Shipley Shelton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-13-67.

23C. PHYSICIAN'S NAME (Type): Perry Shipley Shelton M.D.

23D. ADDRESS: Mercy Hospital.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.

24B. DATE: 4/14/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: B. Pabrowski

ADDRESS: 2818 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-226

BIRTH NO. 67 3691

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3691

1. NAME OF DECEASED (Type or Print): KICAS, CATHERINE LEE

2. DATE AND HOUR OF DEATH: APRIL 14, 1967 | 1:25AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTO. 29

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-06

D. STREET ADDRESS (If rural, give location): 601 S. ~~WELSLEY ST.~~ Wellesley St.

5. SEX: FEMALE

6. RACE: CAUCASION

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 02-01-26

9. AGE (In years last birthday): 41

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINTENANCE

10B. KIND OF BUSINESS OR INDUSTRY: SOLO CUP CO.

11. BIRTHPLACE (State or foreign country): BALTO. MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM WOCKENFUSS DEC'D

14. MOTHER'S MAIDEN NAME: MARGARET BOSMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-14-8297

17. INFORMANT: ST. AGNES RECORDS: WOLKENS & CATON

ADDRESS: AVES. #29

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 463X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Massive Pulmonary Embolism

DUE TO

(B) Thrombophlebitis of legs.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 14 19 67 to APRIL 14 19 67, that (I) (we) last saw the deceased alive on APRIL 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): E.H. WEISS M.D.

23D. ADDRESS: ST. AGNES HOSPITAL; CATON & WILKENS AVES 21229

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/17/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Ave. 21229

3699

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

R-152

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3692 Registered No. X 67 3692

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MORRIS I. RUBINSTEIN

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 | 5:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 901 Flagtree Court

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Sept. 18, 1917	49		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Filling Station	Owner	Poland	USA

13. FATHER'S NAME: Phoebus Rubinstein

14. MOTHER'S MAIDEN NAME: Flora ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W. W. 11 Army

16. SOCIAL SECURITY NO.: 218-07-0103

17. INFORMANT: Mrs. Blanche Rubinstein ADDRESS: 901 Flagtree Court

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypoplasia of Coronary Arteries.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/14/67	Hebrew Young Men	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Farlow	Sol Levinson & Bros. Inc.,	6010 Reisterstown

VS 151-REV. 1/1/65

1967 0003700

1

B-600

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3693 Registered No. 67 3693

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BESSIE O. BURRY

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 9:04 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 3808 Egerton Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3808 Egerton Road

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Jan. 10, 1908
9. AGE (In years last birthday): 59
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Burry
14. MOTHER'S MAIDEN NAME: Gertrude Newberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-32-4717
17. INFORMANT: Mrs. Esther Brodkin
ADDRESS: 5714 Highgate Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E 970.2

(A) Acute Barbiturate Intoxication.

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3808 Egerton Road 15-10

21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 12 (Year) '67 (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Overdose of barbiturate.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/14/67
23C. NAME of CEMETERY or CREMATORY: Baltimore Hebrew
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.
ADDRESS: 6010 Reist., Rd.

VS 151-REV. 1/1/65

N 971 967 000 3701

D-55

BIRTH NO. 67 3694

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3694

1. NAME OF DECEASED (Type or Print): DANNENFELSER GRACE K.

2. DATE AND HOUR OF DEATH: 4-14-67 | 1230 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 9415 DANA VISTA Rd. 21236

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11/17/03

9. AGE (In years last birthday): 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W

10B. KIND OF BUSINESS OR INDUSTRY: Secretary Assoc. U. Drive Co.

11. BIRTHPLACE (State or foreign country): USA.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: CHARLES KRITCHER

14. MOTHER'S MAIDEN NAME: Anna Klunk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-34-2340

17. INFORMANT: Mr David A. Dannenfelser

ADDRESS: 9415 Dana Vis

MEDICAL CERTIFICATION

1B. 465 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) P. EMBOLI — 1 week

DUE TO

(B) HEMORRHAGE — 5 days

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4/7/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: P. EMBOLI

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-7-67 19 67 to 19 ..., that (I) (we) last saw the deceased alive on 7/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): E. HIRSCH M.D.

23D. ADDRESS: U. HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-17-1967

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Lassahn F. Home

ADDRESS: 7401 Belair Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-432

BIRTH NO. 67 3695

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3695

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SCHWARTZ, JOSEPH

2. DATE AND HOUR OF DEATH: 4-12-67 | 11.15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: U.S.A
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-09
D. STREET ADDRESS (If rural, give location): 4019 BONNER ROAD #16

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: [redacted]
9. AGE (In years last birthday): 82
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [redacted] TAILOR
10B. KIND OF BUSINESS OR INDUSTRY: SHOP
11. BIRTHPLACE (State or foreign country): ROMANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: [redacted] ISAAC SCHWARTZ
14. MOTHER'S MAIDEN NAME: [redacted] UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 162-05-5155
17. INFORMANT: NORTH CHARLES GENERAL HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 434.1

CAUSE OF DEATH
(A) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 22 days.
DUE TO
(B) CONGESTIVE HEART FAILURE
DUE TO
(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-21- 1967 to 4-12 1967, that (I) (we) last saw the deceased alive on 4-12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chanthara Suddhimondala M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-12-67
23C. PHYSICIAN'S NAME (Type): MARION FRIEDMAN M.D.
23D. ADDRESS: 5211 HARFORD ROAD 21214

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/13/67
24C. NAME of CEMETERY or CREMATORY: FORBAND
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farkyma
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

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F-432

67 3696

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 3696

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): AMOS S. FIELDS, Sr.

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 9:31 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 307 E. Lafayette Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Feb. 6. 1901
9. AGE (In years last birthday): 66
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Janitor)
10B. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jas. Fields
14. MOTHER'S MAIDEN NAME: Bertie Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-01-2681
17. INFORMANT: Helen Fields
ADDRESS: 307 E. Lafayette Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease. 4221

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 26
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/17/67
23C. NAME of CEMETERY or CREMATORY: Pleasant Rest
23D. LOCATION (City, town, or county) (State): Towson, Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT. APR 17 1967
24B. NAME OF REGISTRAR: Robert E. Fankenna
24C. FUNERAL DIRECTOR: Wm. S. Chatman
ADDRESS: 1701 N. Calhoun St. Balto. Md.

VS 151-REV. 1/1/65

1967 0003704

42-73-75 GG 1

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3697

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3697

1. NAME OF DECEASED (Type or Print): James Elmer Schriefer, Sr. — Schriefer, James

2. DATE AND HOUR OF DEATH: 4/13/67 | 9 35 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE 21224, MD. 31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — Dundalk 53-00
D. STREET ADDRESS (If rural, give location): 1769 BROOKVIEW ROAD 21222

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11-28-1903
9. AGE (In years last birthday): 63
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe fitter
10B. KIND OF BUSINESS OR INDUSTRY: Rever Copper & Brass Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Schriefer
14. MOTHER'S MAIDEN NAME: Louise Kaiser

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-03-0155
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue — ADDRESS: #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Pulmonary Embolis — 1-2 wks
(B) DUE TO: Pneumonia — 1-2 wks
(C): Chronic obstructive pulmonary disease — 6 yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/1 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. A. Sullivan M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): Dr. M. A. Sullivan M.D.
23D. ADDRESS: 4940 Eastern Avenue Baltimore 21224, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 15-1967
24C. NAME of CEMETERY or CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21224

25A. DATE RECEIVED BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrner
25C. FUNERAL DIRECTOR: John J. Duda, Dundalk, Maryland 21222 — ADDRESS

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 7 0 5

H-436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3698 Registered No. 67 3698

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary C. Holter

2. DATE AND HOUR OF DEATH: 4-13-67 | 3 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp. 37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto. Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): White Marsh Md.
D. STREET ADDRESS (If rural, give location): Loreley Beach Rd. 53-00

5. SEX: F. 6. RACE: W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 8. DATE OF BIRTH: Oct 3-1914 9. AGE (In years last birthday): 52 If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home 10B. KIND OF BUSINESS OR INDUSTRY: None 11. BIRTHPLACE (State or foreign country): Dublin Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Francis Chamberlain 14. MOTHER'S MAIDEN NAME: Odella Scarborough

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —— 16. SOCIAL SECURITY NO.: 213-38-7274 17. INFORMANT: William P. Holter Sr. ADDRESS: Loreley Beach Rd White Marsh Md

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 212X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cor Pulmonale
DUE TO
(B) Previous (R) Pneumonectomy
DUE TO
(C) (R) Bronchial Adenoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(1) Acute + Chronic Bronchitis
(2) Possible Acute Myocardial Infarction

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4-9 1967 to 4-13 1967, that (I) (~~we~~) last saw the deceased alive on 4-13 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Michael A. Ellis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4-13-67

23C. PHYSICIAN'S NAME (Type): Michael A. Ellis M.D. 23D. ADDRESS: Mercy Hospital Balto Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 24B. DATE: 4/17/76 24C. NAME of CEMETERY or CREMATORY: ST. STEPHENS 24D. LOCATION (City, town, or county) (State): BRADSHAW BALTO. MD

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967 25B. NAME OF REGISTRAR: Robert E. Farley, M.D. 25C. FUNERAL DIRECTOR: DIPPEL BROS ADDRESS: 7110 BELAIR RD

VS 150-REV. 1/1/65 1967 0 0 3 7 0 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
P-320

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3699 Registered No. 67 3699

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE PETTUS

2. DATE AND HOUR PRONOUNCED DEAD: 4-15-67 4:15 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 827 EDMONDSON AVENUE - Amb. Crew #1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 827 Edmondson Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 1-27-05
9. AGE (In years last birthday): 62
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Pettus
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family
ADDRESS: 1421 Argyle Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-21-67
23C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
23D. LOCATION (City, town, or county) (State): A.A.Co. Md

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
24B. NAME OF REGISTRAR: Robert E. Fahey
24C. FUNERAL DIRECTOR: Sullivan Funeral Home
ADDRESS: 1011-13 N. Arlington Ave

VS 151-REV. 1/1/65

1967 0 0 3707

C-462

BIRTH NO. 67 3700

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3700

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARY ANN CLARKE

2. DATE AND HOUR OF DEATH: April 16, 1967 | 9:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 MELCHOR NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-48
D. STREET ADDRESS (If rural, give location): 506 WOODBOURNE AVE.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 3-10-90
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REGISTERED NURSE
10B. KIND OF BUSINESS OR INDUSTRY: HOSPITAL
11. BIRTHPLACE (State or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ~~XXXXXXXXXXXXXX~~ Carl Kabaski
14. MOTHER'S MAIDEN NAME: JULIA BIALKI
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-40-1814
17. INFORMANT: CHARLES W. CLARKE
ADDRESS: 506 WOODBOURNE AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 331 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

(B) Generalized Cerebrovascular Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

(C) & Senile Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 3 1967 to April 16 1967, that (~~I~~) (we) last saw the deceased alive on April 16 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Herman Brecher M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/17/67.
23C. PHYSICIAN'S NAME (Type): HERMAN BRECHER M.D.
23D. ADDRESS: XX 443 E. 25th Street

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-18-67
24C. NAME of CEMETERY or CREMATORY: PARKWOOD CEMETERY
24D. LOCATION (City, town, or county): PARKVILLE (State): MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: WM. COOK-BROOKS INC.
ADDRESS: 1217 ST. PAUL STREET

VS 150-REV. 1/1/65

S-350

BIRTH NO. 67 3701

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3701

1. NAME OF DECEASED (Type or Print) ~~BIRTHNAME~~ STOEN, BENNETH A. DR.

2. DATE AND HOUR OF DEATH April 12 1967 7:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

House in the Pines, Belvedere

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Lutherville 53-00

D. STREET ADDRESS (If rural, give location): 17 W. Seminary Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	Nov. 22, 1894	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician	Medicine	Blue Earth, Minnesota	U.S.A.

13. FATHER'S NAME: A. C. Stoen

14. MOTHER'S MAIDEN NAME: Bertha Tanold

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Yes——————W.W. One

16. SOCIAL SECURITY NO. 213-48-4384

17. INFORMANT: W. Giles Parker, ADDRESS: 111 Susquenanna Ave, 21204

MEDICAL CERTIFICATION

18. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarct
DUE TO: Arteriosclerotic C.V.D. — 2 days.

(B) Cerebral thrombosis
DUE TO: Arteriosclerotic C.V.D. — 2 1/2 yrs.

(C) Cerebrovascular

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 1 19 67 to April 12 19 67, that (I) (we) last saw the deceased alive on April 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth Kolmerten M.D. Attending Phys. ☐ C. Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	Apr. 15, 1967	Green Mount Crematory	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. APR 17 1967

25B. NAME OF REGISTRAR Robert E. Talbert

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, ADDRESS: 1050 York Road Towson, Md. 21204

VS 150-REV. 1/1/65

1967 0003709

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

5- 600

BIRTH NO. 67 3702

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3702

1. NAME OF DECEASED (Type or Print): MARY AUDREY SAUER

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 10:08 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore G

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 2011 Kennicott Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: June 20, 1920

9. AGE (In years last birthday): ~~47~~ 46

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10B. KIND OF BUSINESS OR INDUSTRY: C. R. Daniels Inc.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wendell Herman

14. MOTHER'S MAIDEN NAME: Mary Oursler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-07-8499

17. INFORMANT: Francis A. Sauer, Montvale, N. J. ADDRESS: 103 Nottingham Ct.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. E819.4

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral Injury.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Ingleside Ave. & Johnny Cake Road 53-00

21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 12 (Year) '67 (Hour) P m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Passenger in auto into fixed object.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Apr. 15, 1967

23C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

23D. LOCATION (City, town, or county) (State): Woodlawn, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Farkuna

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, ADDRESS: 1050 York Road Towson, Maryland

VS 151-REV. 1/1/65

N 856,R67 0003710

E-436

BIRTH NO. 67 3703

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3703

1. NAME OF DECEASED (Type or Print): FRANCIS WYATT ELDER

2. DATE AND HOUR OF DEATH: 4/13/67 1:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Mem. Hosp

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): HYDES. 53-00

D. STREET ADDRESS (If rural, give location): #

5. SEX: Male

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/19/1893

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10B. KIND OF BUSINESS OR INDUSTRY: FARMER.

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George Elder

14. MOTHER'S MAIDEN NAME: FRANCES NORRIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes

(If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 218-36-4454

17. INFORMANT: MRS. JEAN B. ELDER

ADDRESS: HYDE, MD.

MEDICAL CERTIFICATION

18. 420.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial Infarction

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: - 2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert P Doyle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type): Robert Doyle M.D.

23D. ADDRESS: UMH

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/15/67

24C. NAME of CEMETERY or CREMATORY: TRINITY EPISCOPAL CEMETERY

24D. LOCATION (City, town, or county) (State): LONG GREEN, MD.

25A. DATE RECEIVED BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson

ADDRESS: 1050 York Rd 21204

VS 150-REV. 1/1/65

1967 0 0 0 3 7 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-500 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3704 Registered No. 67 3704

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY ELLEN KUHN

2. DATE AND HOUR OF DEATH: April 11, 1967 5 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 818 N. Curley St. Baltimore, Md., 21205

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Md., 21205
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 701
D. STREET ADDRESS (If rural, give location): 818 N. Curley St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	widowed	1/6/1888	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Baltimore, Md.	

13. FATHER'S NAME: Sidney Baxter

14. MOTHER'S MAIDEN NAME: Frances Hagenroeder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT 524 N. Decker Ave. ADDRESS
Lelia Harmel, step-sister

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

(A) Coronary occlusion
DUE TO coronary sclerosis
(B) DUE TO arteriosclerosis heart
(C) arthritis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

malnutrition

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 22 1967 to April 11 1967, that (I) (we) last saw the deceased alive on April 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter A. Anderson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 12 '67

23C. PHYSICIAN'S NAME (Type): Dr. W.A. Anderson M.D.

23D. ADDRESS: 3001 Shannon Drive

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/14/67	Gardens of Faith Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H 620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3705 Registered No. 67 3705

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM HORSEY

2. DATE AND HOUR OF DEATH: 4/13/67 11:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Carroll Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Finksburg 36-00
D. STREET ADDRESS (If rural, give location): 21041

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 8. DATE OF BIRTH: 9/6/98 9. AGE (In years last birthday): 68 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 10B. KIND OF BUSINESS OR INDUSTRY: Wernstein Co 11. BIRTHPLACE (State or foreign country): Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Horsey Sr 14. MOTHER'S MAIDEN NAME: Lula Stevenson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 213-03-7697 17. INFORMANT: wife ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — INTERVAL BETWEEN ONSET AND DEATH

I (A) Metastatic lymphoma
DUE TO
(B) Malignant lymphoma — small cell 12/66
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD = ? pulmonary emboli

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/14 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS: 627 Fairmount

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/17/67 24C. NAME of CEMETERY or CREMATORY: Lake View Memorial 24D. LOCATION (City, town, or county) (State): Sykesville, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967 25B. NAME OF REGISTRAR: [signature] 25C. FUNERAL DIRECTOR: J. F. Eline & Sons Reisterstown, Md. ADDRESS

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 7 1 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3706 Registered No. 67 3706

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edna E. Nowell

2. DATE AND HOUR OF DEATH: 3:30 AM 4/14/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Md. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Balto~~ B. COUNTY: Md.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. City 28-04
D. STREET ADDRESS (If rural, give location): 4508 Mt. View Rd.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 10-2-01
9. AGE (In years last birthday): 65 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William ? Bosley
14. MOTHER'S MAIDEN NAME: Helen ? Madden

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-07-1792
17. INFORMANT: Mrs. Rita Maurice, daughter on Adm — ADDRESS: 4508 Mount View Rd. Balto. Md. 21229

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Middle Cerebral Art. Thrombosis — 4-1-67
DUE TO
(B) ASCVD
DUE TO
(C) Diabetes mellitus
Lower Lobe Pneumonia

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Depressed Psychosis (Lex)

19A. DATE OF OPERATION: 4-8-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: TRACHEOSTOMY - Control Secretn
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-1 1967 to 4-14 1967, that (I) (we) last saw the deceased alive on 4-14 1967 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: D H Griffin M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): DEAN. H. GRIFFIN M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apr. 17, 1967
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: G. Truman Schwab — ADDRESS: 3512 Frederick Ave. Baltimore, Maryland 21229

VS 150-REV. 1/1/65

1967 0003714

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

N-140

BIRTH NO. 67 3707

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3707

1. NAME OF DECEASED (Type or Print): ALTON Gloucester NOBLE

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 5:53 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 661 W. Pratt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02

D. STREET ADDRESS (If rural, give location): 661 W. Pratt Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 1/25/1885

9. AGE (In years last birthday): 81 ~~xxx~~

If Under 1 Yr. Months | Days | Hours | Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Maryland Talbot

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John S. Noble

14. MOTHER'S MAIDEN NAME: Eudocia Merrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-1757

17. INFORMANT: Dennis Noble, Westminister, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/15/1967

23C. NAME of CEMETERY or CREMATORY: Upper Bambury

23D. LOCATION (City, town, or county) (State): Trappe, Md.

24A. DATE RECD BY HEALTH DEPT. APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON, Easton, Md. ADDRESS

VS 151-REV. 1/1/65

1 9 6 7 0 0 3 7 1 5

F-653

BIRTH NO. 67 3708

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3708

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Laura F. Furman

2. DATE AND HOUR OF DEATH: April 16, 1967 | 5:05 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(If not in hospital or institution, give street address or location): 629 McCabe Avenue, Baltimore, Md. 21212

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 21212
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 629 McCabe Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: June 13, 1886
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10B. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Uehr
14. MOTHER'S MAIDEN NAME: Elsa Kuenne

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO. 218-03-1866D
17. INFORMANT: Viola B. Camposonico (Daughter) Same
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 170 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — 2 years
DUE TO
(B) Carcinoma Right Breast — 3 years
DUE TO
(C) H A S H D — 5 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/6 1967 to 4/16 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: I S Zinberg M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): Israel S. Zinberg M.D.
23D. ADDRESS: 4000 W. Northern Parkway

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apr 19, 1967
24C. NAME of CEMETERY or CREMATORY: Balto. Hebrew Congregation
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Eugenia K. Seitz
ADDRESS: 5209 York Rd. Seitz Funeral Home Balto. Md. 21212

VS 150-REV. 1/1/65

67 0 0 3 7 1 6

L-120

BIRTH NO. 67 3709

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3709

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Ruth M. Lupus

2. DATE AND HOUR OF DEATH: April 11, 1967 | 4:20 P. M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D. O. A. St. Agnes Hosp.

40/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-06
D. STREET ADDRESS (If rural, give location): 3201 Strickland St.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: May 7, 1896
9. AGE (In years last birthday): 70
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William H. Finch
14. MOTHER'S MAIDEN NAME: Alice C. Jennings

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. William Finch
ADDRESS: 3123 Strickland St. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1952 19 to 4/11/67 19, that (I) (we) last saw the deceased alive on 3/30/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Herbert W. Lapp M.D. M.D. Attending ☐ Med. Exam. ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): HERBERT W. LAPP, M.D.
23D. ADDRESS: 4804 FREDERICK AVE. BALTIMORE 29, MD. — MI 4-3655

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 14, 1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fogley M.D.
25C. FUNERAL DIRECTOR: G. Truman Schwab
ADDRESS: 3512 Frederick Ave. Balto. Md.

VS 150-REV. 1/1/65

3717

P-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3710 Registered No. 67 3710

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Price, George D. Jr.

2. DATE AND HOUR OF DEATH: 4/12/67 9:10 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital, Balto., Md. 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21223 20-05

D. STREET ADDRESS (If rural, give location): 2510 Ashton St.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11/11/27

9. AGE (In years last birthday): ~~39~~ 39

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Patrolman

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Police

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Dewey Price, Sr.

14. MOTHER'S MAIDEN NAME: Ethel M. Marsh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes (If yes, give war or dates of service): 1946-1947

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margaret D. Price, ADDRESS: 2510 Ashton Street, Baltimore, Md. 21223

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Myocardial Infarction

DUE TO

(B) Angina Pectoris

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: immediate

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12 April 1967 to 12 April 1967, that (I) (we) last saw the deceased alive on 12 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: H. H. Baylus M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 14 April 67

23C. PHYSICIAN'S NAME (Type): Dr. Baylus M.D.

23D. ADDRESS: 1600 Wilkens Ave Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 17, 67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: G. Truman Schwab, 3512 Frederick Ave, Balto. Md. 21229

ADDRESS

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 3 7 1 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3711 Registered No. 67 3711

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Moxley, Mollie

2. DATE AND HOUR OF DEATH: April 13th, 1967, 12:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-05
D. STREET ADDRESS (If rural, give location): 415 S. Bentalou St

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 7/22/1874
9. AGE (In years last birthday): 93
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: X
17. INFORMANT: X
ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Generalized Arteriosclerosis — unknown
DUE TO
(B) Severe dehydration
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L R Jenk M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): SAI ROK PARK M.D.
23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE:
24C. NAME of CEMETERY or CREMATORY: WESTERN CEMETERY
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: F. B. WIPPERT
ADDRESS: 1300 E. Lexington Pl

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-432

BIRTH NO. 67-04403 3712

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3712

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BARBARA ANN BELTZ

2. DATE AND HOUR OF DEATH: 4-14-67 | 3:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: HARFORD 6

C. CITY OR TOWN (If outside city limits, write RURAL and give township): JOPPA (Rural)

62.00

D. STREET ADDRESS (If rural, give location): ~~2309 RECKFORD ROAD~~ 2311 Reckord Road

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): (CHILD) Never Married

8. DATE OF BIRTH: 3-1-67

9. AGE (In years last birthday): If Under 1 Yr. Months: 1 Days: 14 | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND – Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELMER L. BELTZ

14. MOTHER'S MAIDEN NAME: ROSEMARY McMONIGLE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT (~~Father~~) 879-2657 Mr. Elmer L. Beltz

ADDRESS: 2311 Reckord Road Joppa, Maryland 21085

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Diabetes Mellitus, c

(B) DUE TO: acidosis and hyper-

(C): osmolality, Etiology?

INTERVAL BETWEEN ONSET AND DEATH: ? 6 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-13 1967 to 4-14 1967, that (I) (we) last saw the deceased alive on 4-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard D. Bland M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): RICHARD D. BLAND M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 17, 1967

24C. NAME of CEMETERY or CREMATORY: St. Johns Episcopal Church Cem.

24D. LOCATION (City, town, or county) (State): Kingsville, Baltimore Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: Joseph William Foster

ADDRESS: W. Broadway & Williams St. Del Air, Maryland 21014

Joseph William Foster

VS 150-REV. 1/1/65

49-06-46 GG 15-320

BIRTH NO. 67 3713

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3713

1. NAME OF DECEASED (Type or Print): Seitz, Herman

2. DATE AND HOUR OF DEATH: 4/14/67 15.25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore 21224, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 7273 Gough Street #21224

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2-12-21
9. AGE (In years last birthday): 46
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FORK LIFT OPERATOR
10B. KIND OF BUSINESS OR INDUSTRY: CONTINENTAL CAN
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SYLVESTER SEITZ
14. MOTHER'S MAIDEN NAME: CARMELA DE TOTA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): W.W II
16. SOCIAL SECURITY NO. 218-09-6234
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue #21224
ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) 46% Body Burn — 37 h.
DUE TO
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic atherosis

E916.0

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): X
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 7273 Gough st. 53-00
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 3 p.m. 4/12/67
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑
21F. HOW DID INJURY OCCUR? Set clothes on fire WHEN FELL AGAINST KITCHEN STOVE

22. I certify that (I) (this hospital) attended the deceased from 4/12/67 19 to 4/14/67 19, that (I) (we) last saw the deceased alive on 4/14/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Philip G. Coleman M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): Dr. Philip G. Coleman M.D.
23D. ADDRESS: 4940 Eastern Avenue #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Frank Della Rocca
ADDRESS: 322 S. High St

VS 150-REV. 1/1/65

To be approved by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
R-260

67 3714

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3714

1. NAME OF DECEASED (Type or Print): ROBERT RUCKER

2. DATE AND HOUR PRONOUNCED DEAD: April 9, 1967 1:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-63

D. STREET ADDRESS (If rural, give location): 2423 Barclay Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: May 23-1945

9. AGE (In years last birthday): 22

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Rucker

14. MOTHER'S MAIDEN NAME: Beulah Floyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Beulah Rucker ADDRESS: 2423 Barclay St

MEDICAL CERTIFICATION

1B. E984X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wounds of trunk

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): house

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2423 Barclay Street, rear kitchen 12-03

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4-9-67 12:40 P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR?: Started altercation and was shot by police officers

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: April 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Apr 14-67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem

23D. LOCATION (City, town, or county) (State): A.A. Co Md

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Falkum

24C. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 217 E Preston St

VS 151-REV. 1/1

2 1967 0 0 3722

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

FILE NO. 67 3715 — Registered No. 67 3715

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Shelton

2. DATE AND HOUR OF DEATH: April 13, 1967 6:55a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Montebello State Hosp. 91

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Aberdeen 62-28
D. STREET ADDRESS (If rural, give location): 50 Mitchell Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-14-21
9. AGE (In years last birthday): 45 — If Under 1 Yr. Months / Days / Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photographer
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel W. Butler
14. MOTHER'S MAIDEN NAME: Bessie Briggs

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW-II
16. SOCIAL SECURITY NO.: 238053706
17. INFORMANT: Husband, Same as 4 C & D — ADDRESS

MEDICAL CERTIFICATION

1B. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Laennec's Cirrhosis of Liver — 10 years
DUE TO
(B) Unknown cause
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 17 1967 to April 13 1967, that (I) (we) last saw the deceased alive on April 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar J. Pellegrino M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: April 13, 1967
23C. PHYSICIAN'S NAME (Type): Cesar J. Pellegrino M.D.
23D. ADDRESS: Montebello State Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 15 Apr. 67
24C. NAME of CEMETERY or CREMATORY: Cedarwood Cemetery
24D. LOCATION (City, town, or county) (State): Roanoke Rapids, N.C.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Gallagher
25C. FUNERAL DIRECTOR: Tarring Funeral Home — ADDRESS: Aberdeen, Md.

VS 150-REV. 1/1/65

S-536

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3716

M.E. CASE NO. Saunders, Frank

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3716

1. NAME OF DECEASED (Type or Print): DR. FRANK SAUNDERS

2. DATE AND HOUR OF DEATH: 4-12-67 | 9P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1602

D. STREET ADDRESS (If rural, give location): 1029 N. STRICKER ST.

5. SEX: MALE

6. RACE: NEGROID

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-17-92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SAUNDERS

14. MOTHER'S MAIDEN NAME: HATTIE HILL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edith Saunders ADDRESS: 3316 Auchentoroly Ter.

MEDICAL CERTIFICATION

1B. 4 20.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiogenic shock — 1 hr

DUE TO

(B) myocardial infarction — 24 hr

DUE TO

(C) ASCVD — 20 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/12/67 19 to 4/12/67 19, that (I) (we) last saw the deceased alive on 4/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. P. Wilkinson M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): C. P. Wilkinson M.D.

23D. ADDRESS: Johns Hopkins Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-17-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fulton

25C. FUNERAL DIRECTOR: Kelsey Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

J-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3717 Registered No. 67 3717

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mrs Sarah E. Jones

2. DATE AND HOUR OF DEATH: 4/13/67 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 221 N. Fremont Ave

402

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 2/9/00

9. AGE (In years last birthday): 67

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Housekeeping

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augusta Jones

14. MOTHER'S MAIDEN NAME: Mary Ann Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Frances Jones

ADDRESS: 2210 Roslyn Ave Baltimore

MEDICAL CERTIFICATION

1B. 331/X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Intracerebral Hemorrhage (Hx of Hypertension)

DUE TO

(B) Pneumonia, RT

DUE TO

(C) Cardiac hypertrophy

INTERVAL BETWEEN ONSET AND DEATH: U.K. to min

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4/8 1967 to 4/13 1967, that (I) ~~(we)~~ last saw the deceased alive on 4/13 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Nat E. Watson, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: Western Star Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

67 003728

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Q-500
C-416

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3718 Registered No. 67 3718

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Queenie Colbert

2. DATE AND HOUR OF DEATH: 4-13-67 | 2 15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University of Maryland Hospital Greene - Redwood St. Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Anne Arundel Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Crownsville 52-00
D. STREET ADDRESS (If rural, give location): Crownsville State Hosp. - Crownsville

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): unknown
8. DATE OF BIRTH: 2-8-1875
9. AGE (In years last birthday): 92
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown.
10B. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): Unknown.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown.
14. MOTHER'S MAIDEN NAME: Unknown.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown.
17. INFORMANT: Hospital Record
ADDRESS: Same as #3

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4-20.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — 1 hour.
DUE TO
(B) Arteriosclerotic Cardiovascular Disease — 30 years
DUE TO
(C) Gastrointestinal bleeding (mild) — 24 hours

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While ~~At Work~~ ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 4/12 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley L Blum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): STANLEY L BLUM M.D.
23D. ADDRESS: Same as #3

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-18-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE RECD. BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Tarley M.D.
25C. FUNERAL DIRECTOR: Kelson Funeral Home
ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

M-324

BIRTH NO. 67 3719

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3719

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Emily Mitchell

2. DATE AND HOUR OF DEATH: April 14, 1967 | 10:55p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital 1514 DivisionSt Baltimore Md 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 14-01

D. STREET ADDRESS (If rural, give location): Nursing Home Bolton Hill

5. SEX: Female

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Jan. 11, 1894

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland, Reistertown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Allen J. Thompson

14. MOTHER'S MAIDEN NAME: Ella Sims

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-05-1430

17. INFORMANT: Gertrude Cooper-Dau

ADDRESS

MEDICAL CERTIFICATION

1B. 420.01

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) A S H D

DUE TO

(B) CVA

DUE TO

(C) Passive congestion chronic liver and spleen

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 13, 1967 19 to April 14, 1967 19, that (I) (we) last saw the deceased alive on April 16, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): Dr. Amini M.D.

23D. ADDRESS: 1514 Division St -Provident Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-19-67

24C. NAME of CEMETERY or CREMATORY: St. Lukes Cemetery

24D. LOCATION (City, town, or county) (State): Reistertown, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Charles R. Law

ADDRESS: 802 Madison Ave.

VS 150-REV. 1/1/65

3729

1 6
R-250

BIRTH NO. 67 3720

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3720

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANCIS L. REGAN

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 1:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-31
D. STREET ADDRESS (If rural, give location): 609 Brisbane Road

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: June 2, 1889
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate Broker
10B. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stephen J. Regan
14. MOTHER'S MAIDEN NAME: Anna Lenehan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-09-3355
17. INFORMANT: Ronald K. Regan
ADDRESS: 11 Somerset Rd. - 21228

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E 816.4

(A) Acute bronchopneumonia
DUE TO
(B) Laceration of spleen
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Wilkens Avenue 25-41
21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 2 (Year) '67 (Hour) 7:50 PM m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Driver of auto which lost control and struck several parked cars.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-15-67
23C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
23D. LOCATION (City, town, or county) (State): Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
24B. NAME OF REGISTRAR: Robert E. Farkas, MD
24C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave.
ADDRESS

VS 151-REV. 1/1/65

N 865T 2 6 7 0 0 0 3 7 2 8

1W-630

BIRTH NO. 67 3721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3721

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): John Dowthard Ward

2. DATE AND HOUR OF DEATH: 4/14/67 8 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Md. General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: ?
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 1717 St. Paul St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 10/07/15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CAB Driver
10B. KIND OF BUSINESS OR INDUSTRY: Sun Cab Co.
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 347-05-1130
17. INFORMANT: Miss Marlene Ward — ADDRESS: 11112 Reisterstown Rd.-Owings Mills, Md.

MEDICAL CERTIFICATION

1B. 538 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Infarction — 4-10-67
DUE TO
(B) (2) CAROTID THROMBOSIS — 4-10-67
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4/10/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-10 1967 to 4-14 1967, that (I) (we) last saw the deceased alive on 4-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: DHGriffin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): DEAN H. GRIFFIN M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-18-67
24C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Ralph E. Fahrney
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave. — ADDRESS

VS 150-REV. 1/1/65

67 0 0 3 7 2 9

1
5-165

67 3722

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3722

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harry C. Skipper

2. DATE AND HOUR PRONOUNCED DEAD: April 14, 1967 12:00 PM ~~Midnight~~

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 46 Lutheran Hospital

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 2016 Oak Drive

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	May 23/08	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guard	Mercantile Safe Deposit & Trust Co.	Baltimore, Md.	USA

13. FATHER'S NAME: Late - Thomas Skipper

14. MOTHER'S MAIDEN NAME: Late - Millie ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-0589

17. INFORMANT: Mrs. Catherine Skipper ADDRESS: 2016 Oak Drive - 21207

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of abdominal aortic aneurysm.

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☐ Partial XX and that on this basis, death in my opinion resulted from: Natural causes X Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER X
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Werner U. Spitz, M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: April 15, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-18-67	Loudon Park Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Fahey M.D.	Witzke F. D.	4101 Edmondson Ave.

VS 151-REV. 1/1/65

1967 0 0 3730

5-460

BIRTH NO. 1-26-05 3723

M.E. CASE NO. 95506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3723

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Julia Schueler

2. DATE AND HOUR OF DEATH: 4/16/67 10AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ROOM 347B BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE CITY 19-03 D. STREET ADDRESS (If rural, give location): 1307 W. LOMBARD STREET

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	1-26-05	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Bagoin

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Albert Schueler ADDRESS: 3600 McTavish Av/21229

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Infarction — several minutes

(B) DUE TO: Arteriosclerotic Heart Disease — since 1959 or earlier

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 9 1967 to April 16 1967, that (I) (we) last saw the deceased alive on April 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: April 16 '67

23C. PHYSICIAN'S NAME (Type): A. A. MENDOZA M.D.

23D. ADDRESS: Bon Secours Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-19-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Falkenham

25C. FUNERAL DIRECTOR: Witzke F. D.-4101 Edmondson Ave. ADDRESS

VS 150-REV. 1/1/65

1967 003731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3724

BIRTH NO. 67 3724

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bessie e. Ritter

2. DATE AND HOUR OF DEATH: April 12, 1967 | 1:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home, 3520 Hilton Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): X 3520 Hilton Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Cauc	Widowed	Dec. 2, 1882	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ----- Bowers
14. MOTHER'S MAIDEN NAME: Unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Stanley Ritter
ADDRESS: 6012 Montgomery St.

MEDICAL CERTIFICATION

18. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic heart disease — unknown
DUE TO
(B) Arteriosclerosis, general — "
DUE TO
(C) Diabetes mellitus — "

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from March 16, 1962 to April 12, 1967, that (I) (~~we~~) last saw the deceased alive on April 11, 1967, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Abraham B. Hurwitz M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 13, 1967
23C. PHYSICIAN'S NAME (Type): Abraham B. Hurwitz M.D.
23D. ADDRESS: 7501 Liberty Rd., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-15-67
24C. NAME of CEMETERY or CREMATORY: Finksburg Cem.
24D. LOCATION (City, town, or county) (State):

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fallon M.D.
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave.
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H 645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3725 Registered No. 67 3725

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Alice L. Herrlein

2. DATE AND HOUR OF DEATH 12:45 P.M. April 14, 1967

CERTIFICATE AMENDED

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midtown Home, Inc. 808 St. Paul St.

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 6-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 122 N. Rose St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Widowed	1/29/80	87		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Janitoress	School	Maryland	U.S.A.

13. FATHER'S NAME — Weaver

14. MOTHER'S MAIDEN NAME Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 216 54 7412

17. INFORMANT Mrs. Regina A. Hartman — ADDRESS 122 N. Rose St.

MEDICAL CERTIFICATION

4201

1B. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Occlusion — Sudden
DUE TO
(B) A.S.C.V. Disease — ?
DUE TO
(C) ~~Pneumonia~~

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonitis — 3 wk.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar 30 1967 to April 14 1967, that (I) (we) last saw the deceased alive on 4/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 12:35 P.M.

23A. SIGNATURE Joseph S. Blum M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED 4/14/67

23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D. — 23D. ADDRESS 1115 N. CALVERT ST.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-17-67	Holy Redeemer Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT. APR 17 1967 — 25B. NAME OF REGISTRAR Robert E. Stanley M.D. — 25C. FUNERAL DIRECTOR Hartley Wilder — ADDRESS 2334 Jefferson St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from Dr. Joseph S. Blum
4-19-67 M.H.

M. 6351

BIRTH NO. 67 3726

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3726

1. NAME OF DECEASED (Type or Print): GERTRUDE B. MARTIN

2. DATE AND HOUR OF DEATH: 4-14-67 5 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of The Poor 1200 Valley St Baltimore MD 21202

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 1001
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 11.12.1882
9. AGE (In years last birthday): 85
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Steridle
14. MOTHER'S MAIDEN NAME: Mary Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 220-30-1621
17. INFORMANT: Little Sisters of the Poor
ADDRESS:

MEDICAL CERTIFICATION

18. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial
DUE TO
(B) infarction
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to 4.14. 1967, that (I) (we) last saw the deceased alive on 4.14. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Ankudas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4.17.67
23C. PHYSICIAN'S NAME (Type): STANLEY ANKUDAS M.D.
23D. ADDRESS: 1101 MAIDEN CHOICE LANE Balt.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Philip Herwig
ADDRESS: 2024 New Orleans St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W. 320

BIRTH NO. 67 3727

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3727

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOWARD Woods

2. DATE AND HOUR PRONOUNCED DEAD: 4-16-67 6:10 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33/99 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 705

D. STREET ADDRESS (If rural, give location): 513 N. Castle Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Feb.26/12

9. AGE (In years last birthday): 55

If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Woods

14. MOTHER'S MAIDEN NAME: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): --- (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 220-22-6300

17. INFORMANT: Mrs. Lillian M. Woods, 513 N. Castle St.

ADDRESS:

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Apr, 20/67

23C. NAME of CEMETERY or CREMATORY: Balto. Cem.

23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Philip Arnold Sons

ADDRESS: 2024 Orleans St.

VS 151-REV. 1/1/65

1 9 6 7 0 0 3 7 3 5

M-600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3728 Registered No. 67 3728

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Julia Good Meyer

2. DATE AND HOUR OF DEATH: April 13, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 7301 Park Heights Avenue Baltimore, Maryland 21208

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 27-20

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 7301 Park Heights Ave. 8

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Aug. 11, 1869

9. AGE (In years last birthday): 97

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): London, England

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Max Good

14. MOTHER'S MAIDEN NAME: Helen Constadt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 220-44-1568

17. INFORMANT: Mr. Daniel G. Greenbaum ADDRESS: same address

MEDICAL CERTIFICATION

18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronchopneumonia — 2 wks

DUE TO

(B)

DUE TO

(C) General arteriosclerosis — 30 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1955 to April 14 1967, that (I) (~~we~~) last saw the deceased alive on April 14 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jonas Cohen M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): JONAS COHEN M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: 4/14/1967

24C. NAME of CEMETERY or CREMATORY: Metairie Cemetery

24D. LOCATION (City, town, or county) (State): New Orleans, La.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. J. Tilmanstone ADDRESS: Balto. md. north of Pa. ave.

VS 150-REV. 1/1/65

1967 0 0 3 7 3 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R. 2521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3729 Registered No. 67 3729

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROSENSHINE, ANNA

2. DATE AND HOUR OF DEATH: 4/13/67 | 6:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY: BALTIMORE City

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-17

D. STREET ADDRESS (If rural, give location): LEVINDALE NURSING HOME

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 8/6/91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Mescha Silverman

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Leona Goldstein ADDRESS: 5367 Cordelia Ave.

MEDICAL CERTIFICATION

18. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebrovascular accident — 10 days

DUE TO

(B) Myasthenia Gravis — 1½ yrs

DUE TO

(C) Diabetes Mellitus — 27 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Septicemia

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/3/1967 to 4/13/1967, that (I) (we) last saw the deceased alive on 4/13/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hyman Greenfield M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type): HYMAN GREENFIELD M.D.

23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: 4/14/1967

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): Pittsburgh, Pa.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Jack Twist H. ADDRESS: 2100 Eutaw Place Balto., Md. 17

67 3729

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-530 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3730 Registered No. 67 3730

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LA MOTTE, EUGENE W. H.

2. DATE AND HOUR OF DEATH: APRIL 15, 1967 12:30AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTO. 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTO. City 29

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1608

D. STREET ADDRESS (If rural, give location): 609 WOODINGTON RD.

5. SEX: MALE

6. RACE: CAUCASION

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 02-14-79

9. AGE (In years last birthday): 88

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ACCT. DEPT

10B. KIND OF BUSINESS OR INDUSTRY: B&O RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE LA MOTTE DEC'D

14. MOTHER'S MAIDEN NAME: ELIZA SHEETS DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: ST. AGNES RECORDS: WILKENS & CATON AVES ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) advanced ASCVD

DUE TO

(C) gastrointestinal bleeding

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 7 19 67 to APRIL 15 19 67, that (I) (we) last saw the deceased alive on APRIL 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John B. Herts M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: APRIL 15, 1967

23C. PHYSICIAN'S NAME (Type): JOHN B. HERTS M.D.

23D. ADDRESS: ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO, 29, MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/1967

24C. NAME of CEMETERY or CREMATORY: Providence Cemetery

24D. LOCATION (City, town, or county) (State): Gamber, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Wm. J. Tighman & Sons ADDRESS: Balto, Md. Northern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F. 6301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3731 Registered No. 67 3731

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Earnie Ford

2. DATE AND HOUR OF DEATH 4, 16, 67 11 A M

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: 1305 W Mulberry Street
(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1201
D. STREET ADDRESS (If rural, give location): 1305 W Mulberry Street

5. SEX: Female
6. RACE: Col C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2, 8, 12
9. AGE (In years last birthday): 55
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Essex County Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Betty Richards

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-11-7987
17. INFORMANT: Earnest Ford
ADDRESS: 1305 W Mulberry St

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma, far advanced.

INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. N/A

19A. DATE OF OPERATION: N/A
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): N/A
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): N/A
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): N/A

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): N/A
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ N/A
21F. HOW DID INJURY OCCUR? N/A

22. I certify that (I) (~~this hospital~~) attended the deceased from January 16, 1965 to March 28, 1967, that (I) (~~we~~) last saw the deceased alive on March 28, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (did not) view the body after death.

23A. SIGNATURE: Uthman Ray Jr. M.D.
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 17, 1967

23C. PHYSICIAN'S NAME (Type): UTHMAN RAY, JR., M. D.
23D. ADDRESS: 2225 West North Avenue 21216

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4 20 67
24C. NAME of CEMETERY or CREMATORY: Garrett Memorial Park
24D. LOCATION (City, town, or county) (State): Washington Baltimore Brooklyn

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Alfred L. McCleary
ADDRESS: 2303 W North Ave Balt 17

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-33-44
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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3732 Registered No. 67 3732

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SMITH, Winston Louis

2. DATE AND HOUR OF DEATH: 4/15/67 7:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1705 Barclay Street - 21202

12-05

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10/4/1910
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARVER
10B. KIND OF BUSINESS OR INDUSTRY: Pur Family
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: CORNELIUS SMITH
14. MOTHER'S MAIDEN NAME: CHARLOTTE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 231-22-3848
17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave., Balto., Md. 21224
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Adeno~~ Massive hemop — 25 min
DUE TO lysis
(B) Adenocarcinoma lung — 3½ yrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~XX~~ (this hospital) attended the deceased from 4/14 1967 to 4/15 1967, that (I) ~~XX~~ last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~XX~~ (did) ~~XXXX~~ view the body after death.

23A. SIGNATURE: Bruce G. Whipple M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-15-67
23C. PHYSICIAN'S NAME (Type): BRUCE G. WHIPPLE M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 4-17-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): Gloucester VA

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Falkenham
25C. FUNERAL DIRECTOR: Carter-Blanton Inc VA
ADDRESS: Marshall & Hayes 638 N Gloucester St

VS 150-REV. 1/1/65

1967 0 3710

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

m-250

BIRTH NO. 67 3733

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3733

1. NAME OF DECEASED (Type or Print): Robert Mc.Kinney

2. DATE AND HOUR PRONOUNCED DEAD: April 14, 1967 2:35 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1328 W.North Avenue, Baltimore

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

13-03

D. STREET ADDRESS (If rural, give location): 1328 W. North Avenue

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: MARCH 24-1918

9. AGE (In years last birthday): 49

If Under 1 Yr. Months Days Hours Min. / If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY: GEN CONTRACTOR

11. BIRTHPLACE (State or foreign country): GAFFNEY S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT McKINNEY

14. MOTHER'S MAIDEN NAME: ROSSIE BONNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 247-18-7381

17. INFORMANT: KATHNA McKINNEY ADDRESS: 2221 ASHBURTON St

MEDICAL CERTIFICATION

1B. 150X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Carcinoma of esophagus

(A) DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 15, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-18-67

23C. NAME of CEMETERY or CREMATORY: MT AUBURN

23D. LOCATION (City, town, or county) (State): BALTO MD

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Marshall P. Hayes ADDRESS: 638 N Gilmor St

VS 151-REV. 1/1/65

1967 0 0 0 3 7 4 1

1
H-625

BIRTH NO. 67 3734

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3734

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Harrison

2. DATE AND HOUR PRONOUNCED DEAD: April 14, 1967 7:15 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 616 W. Conway Street, Baltimore

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 616 W. Conway Street

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 5/5/1900
9. AGE (In years last birthday): 66
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moses Bowley
14. MOTHER'S MAIDEN NAME: Belle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Walter Harrison ADDRESS: 616 W. Conway St.

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio vascular disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 15, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4.18/67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

1967 0 0 3 7 4 3

B-656 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3735 Registered No. 67 3735

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mathew Vincent Bernard

2. DATE AND HOUR OF DEATH: April 14, 1967 | 7 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 8 N. Ellwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-01
D. STREET ADDRESS (If rural, give location): 8 N. Ellwood Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Sept. 30, 1908	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Baltimore City Sheriff	Baltimore, Maryland	USA

13. FATHER'S NAME: Anthony M. Bernard

14. MOTHER'S MAIDEN NAME: Mathilda IZZO

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-05-1449

17. INFORMANT: Mrs. Mary W. Bernard ADDRESS: 8 N. Decker Ave.

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) myocardial failure
DUE TO arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 3-25- 1953 to 4-14- 1967, that (I) (we) last saw the deceased alive on 4-11- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: John J Gould M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-14-67

23C. PHYSICIAN'S NAME (Type): JOHN J GOULD MD M.D.

23D. ADDRESS: 14 N. EAST AVE - 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/17/'67

24C. NAME of CEMETERY or CREMATORY: Sacred Heart of Jesus Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

1967 00 3743

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

V-623

BIRTH NO. 67 3736

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3736

1. NAME OF DECEASED (Type or Print): SHIRLEY L. VIERECKT

2. DATE AND HOUR PRONOUNCED DEAD: 4-15-67 1:38 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: JOHNS HOPKINS HOSPITAL - DOA

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 9502 Powder Horn Lane

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married.

8. DATE OF BIRTH: Oct. 9 1918

9. AGE (In years last birthday): 48

If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Self Employed

10B. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (State or foreign country): Baltimore.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Holland.

14. MOTHER'S MAIDEN NAME: Elizabeth McShane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Edward C. Viereckt

ADDRESS: 9502 PowderHornRd.

MEDICAL CERTIFICATION

18. E816.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Multiple injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 53-00: Philadelphia Road and Kenwood Avenue

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 15 (Year) '67 (Hour) 1:17 PM

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Driver in auto-Dump truck collision

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): Cremation

23B. DATE: 4/20/67

23C. NAME of CEMETERY or CREMATORY: Greenmount Cem.

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Falkenhan

24C. FUNERAL DIRECTOR: Leonard J. Ruck, inc.

ADDRESS: 5305 Harford Rd.

VS 151-REV. 1/1/65

N869125700037 44

U-52b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3737 Registered No. 67 3737

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Unger, Ferdinand Julius

2. DATE AND HOUR OF DEATH: 04-14-67 | 13.15 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214 27-05

D. STREET ADDRESS (If rural, give location): 3107 Westfield Avenue

5. SEX: M. 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 07-19-81 9. AGE (In years last birthday): 85 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Ferdinand Unger

14. MOTHER'S MAIDEN NAME: Christina Ruhl

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-03-1282

17. INFORMANT: Miss Dorothy C. Unger ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic

DUE TO Cardiovascular disease

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 24 hours post laparotomy (lysis of adhesions)

19A. DATE OF OPERATION: 13 Apr. 67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fair 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 04-07 1967 to 04-14 1967, that (I) (we) last saw the deceased alive on 04-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hyong Sok Lee M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 04-14-67

23C. PHYSICIAN'S NAME (Type): DR. HYONG SOK LEE M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/17/67 24C. NAME of CEMETERY or CREMATORY: Moreland Mem. Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967 25B. NAME OF REGISTRAR: Robert E. Farkas 25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65 1967 0 0 3 7 0 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3738 Registered No. 67 3738

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dencie Palmer Kent

2. DATE AND HOUR OF DEATH: 4-14-67 7:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2711 Kildaire Drive

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21234 27-07

D. STREET ADDRESS (If rural, give location): 2711 Kildaire Drive

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: February 18, 1905.

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10B. KIND OF BUSINESS OR INDUSTRY: College

11. BIRTHPLACE (State or foreign country): unk.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jirah Azor Palmer

14. MOTHER'S MAIDEN NAME: Ella Pope

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 164-09-6520

17. INFORMANT: Mr. Jirah Palmer

ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

(A) Metastatic cancer — 4 mos

DUE TO

(B) Cancer of breast — 10 mos

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1956 to April 14, 1967, that (I) (we) last saw the deceased alive on April 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald Jandorf M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-14-67

23C. PHYSICIAN'S NAME (Type): Donald Jandorf M.D.

23D. ADDRESS: 6077 Harford Road

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/17/67.

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VS 150-REV. 1/1/65

1967 0003716

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-234

BIRTH NO. 67 3739

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3739

1. NAME OF DECEASED (Type or Print): MARY E. WISTLING

2. DATE AND HOUR OF DEATH: April 14, 1967. 4 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1035 E. Northern Parkway

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-48

D. STREET ADDRESS (If rural, give location): 1035 E. Northern Parkway

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married	Oct. 19, 1895.	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife		Maryland	USA

13. FATHER'S NAME: Unk. Lunz

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Edwin R. Wistling ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Embolism — 5 minutes

DUE TO

(B) Arteriosclerosis-Hypertension — 1963-

DUE TO

(C) Diabetes Mellitus — 1965

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1963 19 to April 6-67 19, that (I) (we) last saw the deceased alive on April 6 67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: F. H. Herrmann MD M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-15-67

23C. PHYSICIAN'S NAME (Type): F. H. HERRMANN MD M.D.

23D. ADDRESS: 1710 E 33rd St Baltimore 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/19/67.	Baltimore National Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Fahrney	Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 150-REV. 1/1/65

67 0 3 7 3 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3740 Registered No. 67 3740

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN DOLFI

2. DATE AND HOUR OF DEATH: April 14, 1967. 2:55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21206 26-01

D. STREET ADDRESS (If rural, give location): 4407 Parkmont Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Dec. 18, 1896.

9. AGE (In years lost birthday): 70

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 177-01-1302

17. INFORMANT: Mrs. Marie Mento, 3301 Kentucky Ave. #13 ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

DUE TO

(B) Coronary Arteriosclerosis — 5 years

DUE TO

(C) Arteriosclerotic Cardiovascular Disease — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from Dec. 28 1966 to April 14, 1967, that (I) (~~we~~) last saw the deceased alive on Mar. 10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Adam G Swiss M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 15, 1967

23C. PHYSICIAN'S NAME (Type): ADAM G SWISS M.D.

23D. ADDRESS: 6232 BELAIR ROAD, BALTO., MD. 21206

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/18/67.

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer ~~Cemetery~~ Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS:

VS 150-REV. 1/1/65

1967 00037 18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3741 Registered No. 67 3741

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Giorgilli, Anthony

2. DATE AND HOUR OF DEATH: 15 Apr 67 | 8 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto B. COUNTY: Md
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21206 26-02
D. STREET ADDRESS (If rural, give location): 4302 Valley View Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 11-20-07
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick Layer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francesco Giorgilli
14. MOTHER'S MAIDEN NAME: Vincenza Tucciarelli

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-07-6065
17. INFORMANT: Mrs. Mary Giorgilli
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Oesophagus

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

150 X

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2-24-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca esophagus
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-14-67 19 to 4-15-67 19, that (I) (we) last saw the deceased alive on 4-15-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: T G Dodenhoff M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 15 Apr 67
23C. PHYSICIAN'S NAME (Type): T. G. DODENHOFF M.D.
23D. ADDRESS: M.D. Gen. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

1967 00 3749

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

m-216

BIRTH NO. 67 3742

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3742

1. NAME OF DECEASED (Type or Print): Helen V. Mc.Farland

2. DATE AND HOUR PRONOUNCED DEAD: April 15,1967 7:00 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: City Hospital

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21222 53-00

D. STREET ADDRESS (If rural, give location): 2804 Page Drive

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: February 19,1906.

9. AGE (In years last birthday): 61

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Jacobs

14. MOTHER'S MAIDEN NAME: Ellen T. Rooney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-18-9967

17. INFORMANT: Mr. Charles L. McFarland ADDRESS: (Same)

MEDICAL CERTIFICATION

18. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardio vascular disease.

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Werner U. Spitz, M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

DATE SIGNED: April 15,1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/19/67.

23C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Fahey M.D.

24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. ADDRESS: Md. 21214

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 7 5 0

D-620

BIRTH NO. 67 3743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3743

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Earl P. Darsch

2. DATE AND HOUR OF DEATH: April 15, 1967 | 4:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5302 Elsrode Ave. .14

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-06

D. STREET ADDRESS (If rural, give location): 5302 Elsrode Ave..14

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	married	2-13-1896	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Resident auditor	Bethlehem Steel Co	Baltimore, Md.	USA

13. FATHER'S NAME: William Herman Darsch

14. MOTHER'S MAIDEN NAME: Edith Lee

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW 1	215448761	Mrs Gladys M. Darsch	same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
151X	(A) Carcinoma of Stomach with Carcinomatosis	3 yrs.
	(B) DUE TO ASHD with h.o. myocardial infarction & cong. ht. failure	2 yrs
	(C)	

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 11-64 1964 to 4-15 1967, that (I) (we) last saw the deceased alive on 4-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Hunter Wilson Jr M.D. — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-17-67

23C. PHYSICIAN'S NAME (Type): E. Hunter Wilson Jr M.D. M.D.

23D. ADDRESS: 303 Medical Arts Bldg. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	4-18-67	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Farley M.D.	Leonard J. Ruck Inc	Baltimore, Md.

VS 150-REV. 1/1/65

1967 00375

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
H-455

BIRTH NO. 67 3744

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3744

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES C. HEILMANN

2. DATE AND HOUR PRONOUNCED DEAD: 4-16-67 10:00 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4723 HAZELWOOD AVENUE

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4723 Hazelwood Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: Nov. 11, 1888
9. AGE (In years last birthday): 78
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John A. Heilmann
14. MOTHER'S MAIDEN NAME: Juliet Sims

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214142396
17. INFORMANT: Mary L. Bussard
ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): burial
23B. DATE: 4-19-67
23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck Inc
ADDRESS: Baltimore, Md.

VS 151-REV. 1/1/65

1967000375 8

S-565

BIRTH NO. 67 3745

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3745

1. NAME OF DECEASED (Type or Print): SNEERINGER, MR. JOSEPH H.

2. DATE AND HOUR OF DEATH: 4/14/67 --- 8:00 P.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital, 1000 S. Caton Avenue, Baltimore, Md. 21229

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Pennsylvania~~ Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Gettysburg~~ Baltimore 25-41
D. STREET ADDRESS (If rural, give location): 1000 S. Caton Ave. (Jenkins Mem. Hosp.)

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Dec. 31, 1881

9. AGE (In years last birthday): 85yrs.

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Auto Dealer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Gettysburg, Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David H. Sneeringer

14. MOTHER'S MAIDEN NAME: Catherine Topper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-54-2602

17. INFORMANT: Paul V. Sneeringer, Medical Records Rm.
ADDRESS: 2414 Kentucky

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 493 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs

ANTECEDENT CAUSES

(B) DUE TO:

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C):

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Brain Syndrome

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 5/1 1966 to 4/14 1967, that ~~(I)~~ (we) last saw the deceased alive on 4/14 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: J. Raymond Gladue M.D.
Attending Phys. ☒ Med. Director ☒ Staff Phys. ☐

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): J. Raymond Gladue, M.D.

23D. ADDRESS: Jenkins Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Ruck Funeral Home
ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

1967000375 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530 1

BIRTH NO. 67 3746

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3746

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Rose Adele Smith

2. DATE AND HOUR OF DEATH: April 16, 1967 | 3:15 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1228 E. North Ave.
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 1228 E. North Ave.

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): single
8. DATE OF BIRTH: 11-13-1887
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Dressmaker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christian J. Smith
14. MOTHER'S MAIDEN NAME: Margaret E. Connolly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edward C. Griebel
ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — 6 mo
DUE TO
(B) Hypertension & Arteriosclerosis — 7 years
DUE TO
(C) Cardiovascular Renal

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from September 1966 to April 16 1967, that (I) (~~we~~) last saw the deceased alive on April 6 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Harry B. Scott M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): HARRY B. SCOTT M.D. M.D.
23D. ADDRESS: 721 MEDICAL ARTS BUILDING

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc
ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

967 0 0 3 7 5 4

S-567

BIRTH NO. 67 3747

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3747

1. NAME OF DECEASED (Type or Print): GEORGE SOMMERS

2. DATE AND HOUR OF DEATH: APRIL 13,1967 | 6;15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gould Nursing Home 6116 Belair Road

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21224

53-00

D. STREET ADDRESS (If rural, give location): 505 Fairview Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: June4,1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter Retired

10B. KIND OF BUSINESS OR INDUSTRY: ShipYard

11. BIRTHPLACE (State or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sabastian Sommers

14. MOTHER'S MAIDEN NAME: Elizabeth Hiller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213 01 1225

17. INFORMANT: Mr Charles F. Miller

ADDRESS: 505 Fairview Ave.

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebro vascular accident

INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Renal failure

2 mos.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1965 19 to April 13 1967, that (I) (we) last saw the deceased alive on April 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We) (did)~~ (did not) view the body after death.

23A. SIGNATURE: Charles C. MacMinn M.D.

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): Charles C. MacMinn M.D.

23D. ADDRESS: Linwood & Baltimore Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/17/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.

ADDRESS: BALTIMORE, MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-6161

BIRTH NO. 67 3748

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3748

1. NAME OF DECEASED (Type or Print): CRAWFORD, LILLIAN THOMPSON

2. DATE AND HOUR OF DEATH: 4/15/67 1:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 613 ANNESLIE ROAD

44

5. SEX: Female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 01-15-1900

9. AGE (In years last birthday): 67

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PROMOTION

10B. KIND OF BUSINESS OR INDUSTRY: SALES

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Magruder Thompson

14. MOTHER'S MAIDEN NAME: Elizabeth Mahaol

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-28-8923A

17. INFORMANT: JOHN A. LOVELL

ADDRESS: R.D. #2 KUTZTOWN, PA.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 120X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pulmonary edema

DUE TO

(B) Status post Radical mastectomy Rt.

DUE TO

(C) No residual Tumor

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

U.K. Born

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from apr 14 3pm 1967 to apr 15 1:30 AM 1967, that ~~(I)~~ (we) last saw the deceased alive on apr. 14. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Giselle T Bretz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): DR GISELLE T BRETZ M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/18/67

24C. NAME of CEMETERY or CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: H.W.Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto.12, Md.

VS 150-REV. 1/1/65

0 3 7 5 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3749 Registered No. 67 3749

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anna E. Rusk

2. DATE AND HOUR OF DEATH: April 13, 1967 | 10:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Melchor Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): 2327 N. Charles St.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 11/18/1879
9. AGE (In years last birthday): 87
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Eichorn
14. MOTHER'S MAIDEN NAME: Mary Feldman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-52-0258
17. INFORMANT: Mrs. Mary T. Benson
ADDRESS: 3715 Elkader Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1

(A) ARTERIOSCLEROSIS CARDIO-VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 15 YRS.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from NOV. 1961 to APRIL 13 1967, that (I) (~~we~~) last saw the deceased alive on APRIL 6 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: APRIL 13, 1967
23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.
23D. ADDRESS: 3902 Greenmount Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 4/14/1967
24C. NAME of CEMETERY or CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

1967 0 0 0 3 7 5 7

T-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3750 Registered No. 67 3750

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sarah R. TULL

2. DATE AND HOUR OF DEATH: April 16, 1967 | 3:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 211 Kemble Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01

D. STREET ADDRESS (If rural, give location): 211 Kemble Road 21218

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 1/2/1874

9. AGE (In years last birthday): 93

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fairfax Co., Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rev. Agustus W. Mather

14. MOTHER'S MAIDEN NAME: Caroline Cullison

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-44-2888

17. INFORMANT: Mrs. Robert B. Dexter ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I 332 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Encephalomalacia — 3 months

DUE TO arteriosclerosis

(B) congestive heart failure — 3 months

DUE TO arteriosclerotic heart disease

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 1964 19 to April 16 1967, that (I) ~~(we)~~ last saw the deceased alive on April 14, 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: MB Daniels, Jr. M.D. Attending Phys. ☒ Med. Director ☐ Stall Phys. ☐

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): W. R. DANIELS, Jr. M.D.

23D. ADDRESS: 11 E. Chase St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/1967

24C. NAME of CEMETERY or CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Ralph E. Fahrney

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

67 003750

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3751 Registered No. 67 3751

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANK HUBER

2. DATE AND HOUR OF DEATH: 4-11-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 703 N. GLOVER ST.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-02

D. STREET ADDRESS (If rural, give location): 703 N. GLOVER ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	7-5-1903	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CHAFFEUR	TRANSIT	MARYLAND	U.S.A.

13. FATHER'S NAME: JOHN C.F. HUBER

14. MOTHER'S MAIDEN NAME: CATHERINE E. STEIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Helen C. Huber ADDRESS: 703 N. Glover St.

MEDICAL CERTIFICATION

18. 083.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Congestive Heart Failure

DUE TO

(B) Postencephalitic Parkinsonism

DUE TO

(C) Disease

Edema.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (~~this hospital~~) attended the deceased from March-11- 1940 to April-11- 1967, that (I) (~~we~~) last saw the deceased alive on April 9- 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Wm G Geyer M.D. M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April-13-67

23C. PHYSICIAN'S NAME (Type): WM G GEYER. M.D.

23D. ADDRESS: 156 N. Milton Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-14-67

24C. NAME of CEMETERY or CREMATORY: GARDENS OF FAITH CEM.

24D. LOCATION (City, town, or county) (State): BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Taylor M.D.

25C. FUNERAL DIRECTOR: [illegible] ADDRESS: 2334 Jefferson St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased priar to death); and (6) No physician was in regular attendance on the deceased priar to death. Such written appraval must be obtained before the remains are embalmed or final dispasition is made.

1
S-432

67 3752

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3752

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUSSELL [redacted] SCHULTZ

2. DATE AND HOUR PRONOUNCED DEAD: April 14, 1967 FRI 10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1658 North gate Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 27

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 212189

D. STREET ADDRESS (If rural, give location): 1658 Northgate Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Divorced	Nov 12-1912	54				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shipfitter	Shipyard	Baltimore, Md	U.S.A.

13. FATHER'S NAME: Anton Schultz SR

14. MOTHER'S MAIDEN NAME: Catherine MISER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO -

16. SOCIAL SECURITY NO.: 214-01-6406

17. INFORMANT: Louis V. Schultz (SON) ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 163X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 14, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	MON APR 17-67	Glen Haven	Glen Burnie, Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Farber M.D.	CURTIS E. EVANS	4005 Clarks 21230

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 7 6 0

S-431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3753 Registered No. 67 3753

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles J. Schultz

2. DATE AND HOUR OF DEATH: 4-12-67 5 15 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: A.A.Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena 52-00
D. STREET ADDRESS (If rural, give location): Rt 9-Box 123

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	3/2/04	63		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe Fitter	DuPont	Maryland	U.S.

13. FATHER'S NAME: Charles Schultz

14. MOTHER'S MAIDEN NAME: Mary Krushar

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-10-7844

17. INFORMANT: Mary Agnes Schultz - same ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive GI Hemorrhage

DUE TO

(B) Cirrhosis, liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

581.01 + 199.2

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinomatosis, primary?

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		YES	YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4/10 1967 to 4/12 1967 that ~~(I)~~ (we) last saw the deceased alive on 4/12 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: A. H. Ghiladi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): Abdolhamid Ghiladi M.D.

23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-15-1967	Holy Cross Cemetery	Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Fackenna	George J. Gonce	4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

1967000376 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-536

BIRTH NO. 67 3754

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3754

1. NAME OF DECEASED (Type or Print): Mr. Ambrose L. Smith

2. DATE AND HOUR OF DEATH: 4-12-67 | 2 55 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 37 Mercy Hosp.

(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 8421 Loch Raven Blvd.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 1/29/1884

9. AGE (In years last birthday): 83

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pullman conductor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bernard Smith

14. MOTHER'S MAIDEN NAME: Catherine McKegney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Lillian S. Smith

ADDRESS: 8421 Loch Raven Blvd.

MEDICAL CERTIFICATION

1B. 3/X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Recurrent Cerebrovascular Accident

DUE TO

(B) Previous Cerebrovascular Accident

DUE TO

(C) Arteriosclerosis, Generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(1) Acute Myocardial Infarction (2) Pneumonitis (3) Urinary Tract Infection (4) G.I. Hemorrhage

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 3-31 1967 to 4/12 1967, that (I) (~~we~~) last saw the deceased alive on 4/12 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Michael A. Ellis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): Michael A. Ellis M.D.

23D. ADDRESS: Mercy Hospital Balto Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/15/67

24C. NAME of CEMETERY or CREMATORY: Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home

ADDRESS: 6500 York Rd. Balto., Md. 21212

VS 150-REV. 1/1/

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3755 Registered No. 67 3755

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lillian V. Everhart

2. DATE AND HOUR OF DEATH: 4/13/67 | 12.05p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 House In the Pines N. H.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-17

D. STREET ADDRESS (If rural, give location): 2525 W. Belvedere Ave.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 7/17/1879

9. AGE (In years last birthday): 87

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry C. Block

14. MOTHER'S MAIDEN NAME: Virginia Bandell Marcella

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jessie M. Andrews ADDRESS: 915 Southerly Rd.

MEDICAL CERTIFICATION

1B. 174 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CARCINOMA OF UTERUS — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 12 19 67 to April 13 19 67, that (I) (~~we~~) last saw the deceased alive on April 12 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Albert J Himmelfarb M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): Dr. Albert J. Himmelfarb M.D.

23D. ADDRESS: 3501 St. Paul St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/15/67

24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home ADDRESS: 6500 York Rd. Baltimore, Md. 21212

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 3 7 6 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-636

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3756 Registered No. 67 3756

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM C. CARTER

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 6:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1604

D. STREET ADDRESS (If rural, give location): 1026 N. Appleton Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	MARRIED-SEP.	May 2, 1922	44				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SELF EMPLOYED		N. THUMBERLAND CO., VA.	U.S.A.

13. FATHER'S NAME: CLAYBROOK CARTER

14. MOTHER'S MAIDEN NAME: MINNIE MARIE NUTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Claybrook Carter ADDRESS: 1026 Appleton St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

490 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonita.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/12/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
BURIAL	4-15-67	Arbutus Memorial Pk.	Arbutus,	Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 17 1967	Robert E. Farley, M.D.	MORTON & DYETT F.H.	1701 Laurens

VS 151-REV. 1/1/65

1 9 6 7 0 0 3 7 6 4

1
B-400

BIRTH NO. 67 3757

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3757

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES LEROY BAILEY

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 11:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2736 Baker Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 11-26-1930
9. AGE (In years last birthday): 36
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: VENDING CO.
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELIJAH BAILEY
14. MOTHER'S MAIDEN NAME: BERTIE KELLAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-24-0835
17. INFORMANT: Mrs. Mildred Turner ADDRESS: 1613 Westwood St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 14, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-15-67
23C. NAME of CEMETERY or CREMATORY: Mount Calvery Cem.
23D. LOCATION (City, town, or county) (State): A.A. co. Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
24B. NAME OF REGISTRAR: Geo. E. Fahrney
24C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 Laurens

VS 151-REV. 1/1/65

1967 0003768

S-530

BIRTH NO. 67 3758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3758

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Florence Smith

2. DATE AND HOUR OF DEATH: 4/14/67 [redacted] P | 12 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital 38 Greene & Lombard St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17-03

D. STREET ADDRESS (If rural, give location): 853 Harlem Ave.

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 7/25/93

9. AGE (In years last birthday): 73

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALFRED Smith

14. MOTHER'S MAIDEN NAME: GEORGIANNA LIN BERRY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 30 218 508 920

17. INFORMANT: Hospital Record

ADDRESS: Same as #3

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular disease w Congestive Heart failure. — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B) — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/14 1967, that (I) (we) last saw the deceased alive on 4/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley L Blum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): STANLEY L BLUM. M.D.

23D. ADDRESS: Same as #3.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Clara E. Fallaw

25C. FUNERAL DIRECTOR: Morton & Dyett F.H.

ADDRESS: 1701 Laurens

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 0003766

1

R 2603

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3759 Registered No. 67 3759

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Herman Richardson

2. DATE AND HOUR PRONOUNCED DEAD: April 15, 1967 7:20 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1732 W. Fayette Street, Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02

D. STREET ADDRESS (If rural, give location): 1732 W. Fayette Street

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 7-19-1904

9. AGE (In years last birthday): 62

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CLARODON CO. S.E.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNK.

14. MOTHER'S MAIDEN NAME: MOLLIE DINGLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Amey Fleming

ADDRESS: 1732 W. Fayette

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive

DUE TO cardio vascular disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 15, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-19-67

23C. NAME of CEMETERY or CREMATORY: Carver Mem. Park

23D. LOCATION (City, town, or county) (State): Laurel, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

24B. NAME OF REGISTRAR: Robert E. Falkenhan

24C. FUNERAL DIRECTOR: MORTON & DYETT F.H.

ADDRESS: 1701 Laurens

VS 151-REV. 1/1/65

1 9 6 7 0 0 3 7 6 7

P-40d

BIRTH NO. 67 3760

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3760

1. NAME OF DECEASED (Type or Print): PEELE, Julius NMI

2. DATE AND HOUR OF DEATH: April 12, 1967 | 10:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-03

D. STREET ADDRESS (If rural, give location): 1734 N. Smallwood Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Negro Married

8. DATE OF BIRTH: 11/4/22

9. AGE (In years last birthday): 44

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fork Lift Operator

10B. KIND OF BUSINESS OR INDUSTRY: Kennecott Refinning

11. BIRTHPLACE (State or foreign country): Williamston, N. C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Peele

14. MOTHER'S MAIDEN NAME: Emma Willard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): 1/3/43 - 12/18/45

16. SOCIAL SECURITY NO.: 245-42-1089

17. INFORMANT: VA Hospital Records, Balto., Md 21218 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163 X

(A) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 8 months

DUE TO

(B) Carcinoma of Lung

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 29th 19 67 to April 12th 19 67, that (I) (we) last saw the deceased alive on April 12th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ralph H Twining M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: April 13, 1967

23C. PHYSICIAN'S NAME (Type): RALPH H. TWINING M.D.

23D. ADDRESS: Veterans Administration Hospital, 3900 Loch Raven Blvd., Balto., Md 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: Smith Chapel Cem.

24D. LOCATION (City, town, or county): Williamston (State): N.C.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Horton & Dyer F.H.

ADDRESS: 1701 Lawrence

VS 150-REV. 1/1/65

67 0 0 3 7 6 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-253
C-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3761 Registered No. 67 3761

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNIE C. McINTOSH (CLASSIE)

2. DATE AND HOUR OF DEATH: 4-15-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1601 McKean Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-02
D. STREET ADDRESS (If rural, give location): 1601 McKean Avenue

5. SEX: F.
6. RACE: N.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 1-1-1908
9. AGE (In years last birthday): 59
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): OKORNIA CO, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: OWENS OWNES
14. MOTHER'S MAIDEN NAME: MOLLIE OWNES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Francis P. McIntosh ADDRESS: 1601 McKean

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 171X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — 3 months
DUE TO
(B) metastatic adenocarcinoma — unknown
DUE TO
(C) Adenocarcinoma of Cervix — unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease — unknown

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 7-19 1962 to 3-28 1967, that (I) (~~we~~) last saw the deceased alive on 3-28 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: John J Chinell M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-17-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: Mountain Spring Cem.
24D. LOCATION (City, town, or county) (State): Greenville, S.C.

25A. DATE REC'D BY HEALTH DEPT.: APR 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

3769

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-360

BIRTH NO. 67 3762

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3762

1. NAME OF DECEASED (Type or Print): ROBENA WHITE

2. DATE AND HOUR OF DEATH: 4/16/67 2⁰⁰ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIV. HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALT
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALT.
D. STREET ADDRESS (If rural, give location): 2514 HURON ST

25-33

5. SEX: F
6. RACE: N N
7. (MARRIED) NEVER MARRIED WIDOWED, DIVORCED (specify)
8. DATE OF BIRTH: 5/10/16
9. AGE (In years last birthday): 50
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): USA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLIE BURNLEY
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: PT
ADDRESS:

MEDICAL CERTIFICATION

18. 4468 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) LACTIC ACIDOSIS 2° RENAL FAILURE — 1 wk
DUE TO
(B) ART. NEPHROSCLEROSIS — YEARS
DUE TO
(C) —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/16/67 19 to 4/16/67 19, that (I) (we) last saw the deceased alive on 4/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H L Kerr M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Talley M.D.
25C. FUNERAL DIRECTOR: Charles A Rice
ADDRESS: 661 W Barre St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-453

BIRTH NO. 67 3763

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3763

1. NAME OF DECEASED (Type or Print): JOSEPH F. ROLAND JR.

2. DATE AND HOUR OF DEATH: 4/16/67 5:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

15-04

D. STREET ADDRESS (If rural, give location): 1943 CLIFTON AVE.

5. SEX: MALE

6. RACE: NEGROID

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 10-20-00

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH ROLAND

14. MOTHER'S MAIDEN NAME: MAGGIE PAGE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Marion Matthews ADDRESS: 2720 E. Federal St

MEDICAL CERTIFICATION

18. 162.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Bronchogenic CA — INTERVAL BETWEEN ONSET AND DEATH: ~6 months

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 3/29 1967 to 4/16 1967, that I (we) last saw the deceased alive on 4/16 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) view the body after death.

23A. SIGNATURE: S.W. Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/16/67

23C. PHYSICIAN'S NAME (Type): S.W. SPAULDING M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/21/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Fisher M.D.

25C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1967 0 0 3 7 7 1

S-53d

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3764

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3764

1. NAME OF DECEASED (Type or Print): George Elwood Sentz

2. DATE AND HOUR OF DEATH: 4/15/67 | 4:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. of Maryland Hosp
38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY: Adams
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Littlestown, Pa. V-35
D. STREET ADDRESS (If rural, give location): R.D. #1

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/25/10
9. AGE (In years last birthday): 57
(If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe worker
10B. KIND OF BUSINESS OR INDUSTRY: Shoe Manufac
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Sentz
14. MOTHER'S MAIDEN NAME: Jennie ~~Keffer~~ Keefer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No ~~Unknown~~
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 197-01-4625
17. INFORMANT: self
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovasc Collapse — 1 h
DUE TO
(B) Dissecting Aneurism — 1 week
DUE TO
(C) Athrosclerosis — unknown

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/10 19 67 to 4/15 19 67, that (I) (we) last saw the deceased alive on 4/15/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David A. Shafritz
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): David A. Shafritz M.D.
23D. ADDRESS: Univ of Maryland Hosp Balt Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: St. James Cemetery
24D. LOCATION (City, town, or county) (State): Nr. Littlestown, Adams Co., PA.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Richard A. Little
ADDRESS: Littlestown, PA

VS 150-REV. 1/1/65

M-452

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3765 Registered No. 67 3765

M.E. CASE NO. 67-89106

1. NAME OF DECEASED (Type or Print): KIMBERLY M. MULLINS.

2. DATE AND HOUR OF DEATH: 4-15-1967 | 11.25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 25 25-04

D. STREET ADDRESS (If rural, give location): 3531 4TH. ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
FEMALE	WHITE	BABY	4-15-1967				6	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: JESSE MULLINS JR.

14. MOTHER'S MAIDEN NAME: JO ANNE JOHNSTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory Distress Syndrome — 5 hrs

DUE TO (probably hyaline membrane

(B)

DUE TO → Prematurity

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6 30 pm 4/15 1967 to 11 25 pm 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William C. MacLean M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): DR. WM. MACLEAN M.D.

23D. ADDRESS: Johns Hopkins Hospital Baltimore 21205

24A. BURIAL CREMATION, REMOVAL (Specify): CREMATORIUM

24B. DATE: 4-16-67

24C. NAME of CEMETERY or CREMATORY: THE JOHNS HOPKINS HOSPITAL

24D. LOCATION (City, town, or county) (State): BALTIMORE., MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL ADDRESS:

VS 150-REV. 1/1/65

H-252

67-07162

BIRTH NO. 67 3766

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3766

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): GORDON CONRAD HUGGINS JR.

2. DATE AND HOUR OF DEATH: 4/15/67 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: CITY Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21207 53-00
D. STREET ADDRESS (If rural, give location): 7114 BEXHILL ROAD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 4/8/67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 6½ Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: GORDON CONRAD HUGGINS SR.
14. MOTHER'S MAIDEN NAME: CAROL A
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: PARENTS — AS ABOVE ADDRESS:

MEDICAL CERTIFICATION

18. 751.1

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARDIO-RESPIRATORY ARREST
DUE TO
(B) MENINGOENCEPHALOCELE — 6½ DAYS
DUE TO
(C) WITH RUPTURE; MULTIPLE CONGENITAL ANOMALIES

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/8 1967 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Duane F. Alexander M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/15/67
23C. PHYSICIAN'S NAME (Type): DUANE F. ALEXANDER M.D.
23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
24B. DATE: 4-15-67
24C. NAME of CEMETERY or CREMATORY: Johns Hopkins Hospital
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farkas M.D.
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL ADDRESS:

VS 150-REV. 1/1/65

D-120

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67-07150 67 3767

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3767

1. NAME OF DECEASED (Type or Print): DAVIS, Baby girl.

2. DATE AND HOUR OF DEATH: 4-15-67 6:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND, B. COUNTY: BALTIMORE CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-03
D. STREET ADDRESS (If rural, give location): 2337 E. MONUMENT ST.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 4-13-67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 2 Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ROBERT C. DAVIS, JR.
14. MOTHER'S MAIDEN NAME: KAREN HUTCHINSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 751.2 I

(A) Hydrocephalus and meningomyelocele — 1 day

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Right Femoral Fracture

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Elizabeth Maxwell M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/15/67.
23C. PHYSICIAN'S NAME (Type): ELIZABETH MAXWELL M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: The Johns Hopkins Hospital
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: R. S. E. Farley, M.D.
25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL
ADDRESS:

VS 150-REV. 1/1/65

1967 0 0 3 7 7 5

R-167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3768 Registered No. 67 3768

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HELEN ELIZABETH ROBERTSON

2. DATE AND HOUR OF DEATH: April 16, 1967 | 12:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Essex (21) 53-00

D. STREET ADDRESS (If rural, give location): 14 Orville Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: June 15, 1893

9. AGE (In years last birthday): 73

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10B. KIND OF BUSINESS OR INDUSTRY: Canning Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Foltz

14. MOTHER'S MAIDEN NAME: Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 212 09 7408

17. INFORMANT: Elizabeth Ustasiewski ADDRESS: 1735 Eastern Blvd. 21

MEDICAL CERTIFICATION

18. 420.1 + 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Occlusion — 15 Minutes

DUE TO

(B) HCVD. — several yrs

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1954 to 4/16 1967, that (I) (we) last saw the deceased alive on 3/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Platt M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): J. Jay Platt, M.D.

23D. ADDRESS: 406 Eastern Blvd. Balto., Md. 21221

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Bruzdzinski

ADDRESS: Bruzdzinski Funeral Home 1407 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3769 Registered No. 67 3769

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROGERS, HARRY I. SR.

2. DATE AND HOUR OF DEATH: 4-15-67 at 3:30 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-03
D. STREET ADDRESS (If rural, give location): 316 E. 25th St. # 21218

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/12/90
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROGERS
14. MOTHER'S MAIDEN NAME: HARRIETTE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-03-2309
17. INFORMANT: RHODA ROGERS ADDRESS: 316 E. 25th St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 434.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGESTION HEART FAILURE

DUE TO

(B) UREMIA - RESPIRATORY ACIDOSIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-14 1967 to 4-15 1967, that (I) (we) last saw the deceased alive on 4-15-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Montoya M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-15-67
23C. PHYSICIAN'S NAME (Type): ALEJANDRO MONTOYA M.D.
23D. ADDRESS: NORTH CHARLES GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: LORRAINE PARK
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Paul E. Chenowith Sr. ADDRESS: 2617 Chestnut Ave.

VS 150-REV. 1/1/65

967003772

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-540

63-16530

BIRTH NO. 67 3770

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3770

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HIMMEL Timothy

2. DATE AND HOUR OF DEATH: 10 50 AM 4/15/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI Hosp. of BALTO

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. md 22214
D. STREET ADDRESS (If rural, give location): 5603 HILLTOP AVE # 6

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF DATE OF BIRTH: 6-15-63
9. AGE (In years last birthday): 4
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTO. md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert
14. MOTHER'S MAIDEN NAME: PATRICIA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: ROBERT HIMMEL
ADDRESS: 5603 HILLTOP AVE

MEDICAL CERTIFICATION

18. 756.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) cardio-vascular collapse
DUE TO TE fistula post-op — ~~from birth~~
(B) colon transplant small bowel volvulus i resection
DUE TO
(C) T-E fistula — from birth

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-10-67 4-14-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-10- 1967 to 4-15 1967, that (I) (we) last saw the deceased alive on 4-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. A. Torres M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-15 67
23C. PHYSICIAN'S NAME (Type): L. A. Torres M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: MAYES CHAPLE
24D. LOCATION (City, town, or county) (State): BALTO. CO.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan M.D.
25C. FUNERAL DIRECTOR: Paul E. Clemens
ADDRESS: 3617 Chertwin Ave.

VS 150-REV. 1/1/65

67 3770

H-630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3771 Registered No. 67 3771

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mrs. MARGARET MURPHY HART

2. DATE AND HOUR OF DEATH: April-16-67 | 3.45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 HillCrest Nursing Home Stoney Run Lane (21210)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): 42-East-26th-St. (21218)

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: March-6-1877
9. AGE (In years last birthday): 90
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard D. Murphy
14. MOTHER'S MAIDEN NAME: Margaret E. Mills

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-52-2913
17. INFORMANT: RichardH.Hart (son) ADDRESS: 42-E-26th-St. 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Disease — Several years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1964 to April 16, 1967, that (I) (we) last saw the deceased alive on Apr. 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank N. Ogden M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 17, 67.
23C. PHYSICIAN'S NAME (Type): FRANK N. OGDEN. M.D.
23D. ADDRESS: 2701 N. Calvert St

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: Apr-18-67
24C. NAME of CEMETERY or CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Baltimore-Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108-W-North-Av 21201

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3772 Registered No. 67 3772

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ~~Gate~~, Maude S. GATES

2. DATE AND HOUR OF DEATH: 4/16/1967 1:25 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland Guilford

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md. B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Fountain~~ Bel Air 62-00
D. STREET ADDRESS (If rural, give location): Box #18 · Rd B (RFD#3, Box#18 Conowingo Road)

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 9/9/88
9. AGE (In years last birthday): 78
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (State or foreign country): Md Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A. USA

13. FATHER'S NAME: John Orr
14. MOTHER'S MAIDEN NAME: Susan Little

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Client
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. 420.1 260X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarct
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 19 67 to 4/16 19 67, that (I) (we) last saw the deceased alive on ____ 19 ____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel C Wilkerson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): Daniel C Wilkerson M.D.
23D. ADDRESS: 421 Register Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apr. 18, 1967
24C. NAME of CEMETERY or CREMATORY: Bel Air Memorial Gardens
24D. LOCATION (City, town, or county) (State): Bel Air, Harford Co., Maryland 21014

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

VS 150-REV. 1/1/65

1967 0203 Joseph William Foster

H-155

BIRTH NO. 67 3773

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3773

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Dr. Hoffmann, Friedrich W

2. DATE AND HOUR OF DEATH: April 15 1967 — 11 50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Belair — 62-32
D. STREET ADDRESS (If rural, give location): 1601 Westwood Dr.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 11/24/10
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): doctor
10B. KIND OF BUSINESS OR INDUSTRY: Edgewood-Arsenal Chemist
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Hans Hoffmann
14. MOTHER'S MAIDEN NAME: Bertel Z Walters

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-32-7144
17. INFORMANT: (wife) 838-6865 Mrs. Valeska R. Hoffmann — ADDRESS: 1601 Westwood Drive Bel Air, Maryland 21014

MEDICAL CERTIFICATION

1B. 15 7X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Massive GI Hemorrhage — 2 weeks
DUE TO
(B) Penetrating ulcer, stomach
DUE TO
(C) Carcinoma, pancreas — 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Dec 1966
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Obstructive Jaundice
20A. AUTOPSY? (Yes or No): yes.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from August 1966 to April 15 1967, that (I) (~~we~~) last saw the deceased alive on April 15 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lester A. Wall Jr. M.D. — Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/15/67
23C. PHYSICIAN'S NAME (Type): LESTER A. WALL JR. M.D.
23D. ADDRESS: 1039 St. Paul St. Baltimore Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apr. 17, 1967
24C. NAME of CEMETERY or CREMATORY: Bel Air Memorial Gardens
24D. LOCATION (City, town, or county) (State): Bel Air, Harford Co., Maryland 21014

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Tankey M.D.
25C. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
Joseph William Foster

VS 150-REV. 1/1/65

B-67

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3774 Registered No. 67 3774

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LUTHER BIRMINGHAM Meredith SR.

2. DATE AND HOUR OF DEATH: 4-13-67 | 10¹⁵ A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 2917 St. Paul Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 1/14/98
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Confectionary Industry
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Birmingham
14. MOTHER'S MAIDEN NAME: Gertrude Meredith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 213-03-8408
17. INFORMANT: Family records
ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PNEUMONIA — 2 days.
DUE TO
(B) CEREBROVASCULAR ACCIDENT
DUE TO
(C) ARTERIOSCLEROTIC CEREBRO-VASCULAR DISEASE.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-19 1967 to 4-13 1967, that (I) (we) last saw the deceased alive on 4-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Luther R. Hamilton Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-13-67
23C. PHYSICIAN'S NAME (Type): E. R. Hamilton M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apl. 15, 1967
24C. NAME of CEMETERY or CREMATORY: St. James Cemetery
24D. LOCATION (City, town, or county) (State): My Ladys Manor, Monkton, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Charles E. Falkney M.D.
25C. FUNERAL DIRECTOR: John Burns' Sons, Towson, Maryland
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-580

67-07346

BIRTH NO. 67 3775

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3775 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Boy Goehner

2. DATE AND HOUR OF DEATH: 4-15-67 | 3:18 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: U.S.A. Balto. C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Kingsville 53-00
D. STREET ADDRESS (If rural, give location): Jerusalem Road.

5. SEX: M
6. RACE: CAU
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): N.M.
8. DATE OF BIRTH: 4-14-67
9. AGE (In years last birthday):
If Under 1 Yr. Months: Days: 1 Hours: 24 Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Loren Goehner
14. MOTHER'S MAIDEN NAME: Grace E. Strack

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr Loren Goehner ADDRESS: Jerusalem Road

MEDICAL CERTIFICATION

18. 763.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) pending autopsy
DUE TO (B) Cardiomegaly
DUE TO (C) pulmonary congestion.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): X
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 14 1967 to April 15 1967, that (I) (we) last saw the deceased alive on April 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: K. Shaw M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): K. SHAW M.D.
23D. ADDRESS: Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-17-1967
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 3701 Belair Rd

VS 150-REV. 1/1/65

1967 0003783

C-462

BIRTH NO. 67 3776

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3776

1. NAME OF DECEASED (Type or Print): ANNA LAURA CLARKE

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 11:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 52 Seversky Court

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3/23/1900
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALES LADY
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): CANADA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS ARNOLD
14. MOTHER'S MAIDEN NAME: ANNIE McKAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 372-16-6469
17. INFORMANT: MILTON CLARK
ADDRESS: ABOVE

MEDICAL CERTIFICATION

1B. E812.4

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Old Eastern Avenue at Weber Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4-13-67 10:15 P.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by car 53-00

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: April 14, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): REMOVAL
23B. DATE: 4/16/67
23C. NAME of CEMETERY or CREMATORY: LONDON
23D. LOCATION (City, town, or county) (State): LONDON ONTARIO CANADA

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Connolly JH
ADDRESS: 300 Mace

VS 151-REV. 1/1/65

N 869 R 67 0 0 3 7 8 4

SAB-48-97-34

15-543

BIRTH NO. 67 3777

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3777

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LUCY A. SMALLWOOD

2. DATE AND HOUR OF DEATH: 4-16-67 | 2:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 Baltimore City Hospital, 4940 Eastern Avenue, Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 2401 HAMMONDS FERRY 063 21227

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 5-28-94

9. AGE (In years last birthday): [redacted] 72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: Housewife & home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Drury

14. MOTHER'S MAIDEN NAME: Anna Walsh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Records: BCH-4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident — 2 mos

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 ✓

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-29-67 19 67 to 4-16 19 67, that (I) (we) last saw the deceased alive on 4-16-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P. J. McLeod M.D. — Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-16-67

23C. PHYSICIAN'S NAME (Type): P. J. McLEOD M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. BALTIMORE CITY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/20/67

24C. NAME of CEMETERY or CREMATORY: Meadowridge Mem Pk

24D. LOCATION (City, town, or county) (State): Dorsey, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Tankersley

25C. FUNERAL DIRECTOR: John J. Conway & Sons

ADDRESS: 967 Q. John B. Cole and Son Inc. Balto 23, Md

VS 150-REV. 1/1/65

1
B-656

BIRTH NO. 67 3778

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3778

1. NAME OF DECEASED (Type or Print): GEORGE D. BOERNER

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 1:42 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2343 Sidney Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	3/27/26	41				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Social Security	Maryland	

13. FATHER'S NAME: George

14. MOTHER'S MAIDEN NAME: Agnes Mahlstedt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W # II

16. SOCIAL SECURITY NO.: 219 18 7765

17. INFORMANT: Family - Same ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. E823.4

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [Y] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Patapsco Avenue west of Fairhaven Ave. 25-05

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4-17-67 1:10 A.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Passenger in car that struck pole

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] (Partial) and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
B	4/20.67	Baltimore National	Baltimore

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 18 1967	Ralph E. Falkenstein	McCully - 130 E. Fort Ave.	

VS 151-REV. 1/1966

V 8 6 1 3 8 / 0 0 0 3 7 8 6

36-16-12
EGL

51-351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3779 Registered No. 67 3779

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TRESSIE A STUMP

2. DATE AND HOUR OF DEATH: 4/16/67 8:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-09
D. STREET ADDRESS (If rural, give location): 3825 HUDSON STREET 21224

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married
8. DATE OF BIRTH: 8-15-90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GRADER
10B. KIND OF BUSINESS OR INDUSTRY: FOOD CANNING
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: GEORGE
14. MOTHER'S MAIDEN NAME: SUSAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 236-12-4550
17. INFORMANT: BCH: RECORDS 4940 EASTERN AVENUE 21224 ADDRESS

MEDICAL CERTIFICATION

18. 331X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cardiac arrest
DUE TO
(B) CVA — 1 wk.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hiatus Hernia & anemia — 6 years

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1963 to 4/16 1967, that (I) (we) last saw the deceased alive on 4/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Judith Hall M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): JUDITH HALL M.D.
23D. ADDRESS: 4940 EASTERN AVENUE 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: STUMP CEM.
24D. LOCATION (City, town, or county) (State): LANDES, W. VA.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: W. Brooke Bradley, Dundalk, Md. ADDRESS

VS 150-REV. 1/1/65

1967 0 0 3 7 8 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Baby burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-621

Baltimore

BIRTH NO. 67 3780

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3780

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BARKOVICH, JOHN

2. DATE AND HOUR OF DEATH: 4-15-67 10.30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE & COUNTY: MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 31 2-02
D. STREET AND NUMBER: 122 S. WOLFE ST.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-15-1884
9. AGE (In years last birthday): 83
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Yugoslavia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Blase ?
14. MOTHER'S MAIDEN NAME: Mary ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-09-2315A
17. INFORMANT: Mrs. Lillian Barkovich
ADDRESS:

MEDICAL CERTIFICATION

18. 540.0 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) GI HEMORRHAGE — 3 WEEKS
DUE TO
(B) GASTRIC ULCER — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from 4/15 1967 to 4/15 1967, that (I) (~~we~~) last saw the deceased alive on 4/15 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: S. Mishkin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/15/67
23C. PHYSICIAN'S NAME (Type): S. MISHKIN M.D.
23D. ADDRESS: JHH

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: Garden of Faith
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: Joseph B. Zarnowski
ADDRESS: 563 S. Conkling

VS 150-REV. 1/1/65

W-456

BIRTH NO. 67 3781

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3781

1. NAME OF DECEASED (Type or Print): WILMER, WILLIE MAE

2. DATE AND HOUR OF DEATH: 4/16/67 9:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIV. HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: BALTO.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALT. 15-01
D. STREET ADDRESS (If rural, give location): 1375 N. GILMOR ST

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 9/1/21
9. AGE (In years last birthday): 45
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): USA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN MASON
14. MOTHER'S MAIDEN NAME: EMMA COOK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 218-18-1776
17. INFORMANT: Emma Mason
ADDRESS: 1375 Gilmor St.

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) EXFOLIATIVE DERMATITIS — WKS
DUE TO
(B) CA OF CX — YEARS
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11/67 19 to 4/16/67 19, that I (we) last saw the deceased alive on 4/16/67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H L Kiracofe M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): H. L. KIRACOFE M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: BALTO. NAT'L. CEM.
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Fankenna
25C. FUNERAL DIRECTOR: KELSON FUNERAL HOME
ADDRESS: 1348 CALHOUN ST

VS 150-REV. 1/1/65

1967 0 0 3 7 8 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
J-250

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3782 Registered No. 67 3782

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MYRTLE JACKSON

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 9:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1220 N. Stricker Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-2-09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Conaway
14. MOTHER'S MAIDEN NAME: Elizabeth Harcum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Alfred Vaughn
ADDRESS: 2423 Arunah Ave.

MEDICAL CERTIFICATION

18. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 4-18-67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
24B. NAME OF REGISTRAR: Robert E. Falkenstein
24C. FUNERAL DIRECTOR: Kelson Funeral Home
ADDRESS: 1348 Calhoun St.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 7 9 0

S-526

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3783 Registered No. 67 3783

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH SHOEMAKER

2. DATE AND HOUR OF DEATH: 4-15-67 at 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-12

D. STREET ADDRESS (If rural, give location): 2429, Shirley Avenue

5. SEX: F

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 4-3-90

9. AGE (In years last birthday): 77

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK CLARK

14. MOTHER'S MAIDEN NAME: JANE DOWMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JANE FRAZIER ADDRESS: 1007 W. 43rd St.

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Multiple Embolism

DUE TO

(B) Peripheral Shock.

DUE TO

(C) Arteriosclerotic Cardiovascular disease.

INTERVAL BETWEEN ONSET AND DEATH

2 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-13-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Femoral Artery occlusion (left)

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-14-1967 to 4-15-1967, that (I) (we) last saw the deceased alive on 4-15-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-15-67

23C. PHYSICIAN'S NAME (Type): Dr. P. J. JAMES M.D.

23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-19-67

24C. NAME of CEMETERY or CREMATORY: Mt. Pleasant Cem.

24D. LOCATION (City, town, or county) (State): Owings Mill, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

1967 00 0 3 7 9

1
C-355

BIRTH NO. 67 3784

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3784

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GUY COTTMAN

2. DATE AND HOUR PRONOUNCED DEAD: 4-16-67 3:20 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33/99 JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 904 Wheeler Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Jan. 11 1947
9. AGE (In years last birthday): 20
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Martin Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Alphonso Cottman Sr.
14. MOTHER'S MAIDEN NAME: Drunell Minor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-50-0537
17. INFORMANT: Alphonso Cottman ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X 216-50-0537

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot wound of neck
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Hargrove and Trenton Streets 12-05
21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 16 (Year) '67 (Hour) 3:10 AM m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Shot during altercation

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/19/67
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Gk.
23D. LOCATION (City, town, or county) (State): Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
24B. NAME OF REGISTRAR: Robert E. Faulkner
24C. FUNERAL DIRECTOR: Arlington J. Phillips
ADDRESS: 1722 N. Monroe St.

VS 151-REV. 1/1/65

N874.4967000 3792

M-56b

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3785

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3785

1. NAME OF DECEASED (Type or Print): Joseph C. Monroe

2. DATE AND HOUR OF DEATH: 4-13-67 7:16 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 25-32
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore # 21225
D. STREET ADDRESS (If rural, give location): 429 Roundview Road.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married.
8. DATE OF BIRTH: 6-9-09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Monroe
14. MOTHER'S MAIDEN NAME: Bessie Hammond.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-07-1526
17. INFORMANT: Maude Monroe
ADDRESS: Same

MEDICAL CERTIFICATION

18. 420.1 I 260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 1 day
DUE TO
(B) Arteriosclerotic Cardio-vascular dz — 10 years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart failure — 1 week; GI Bleeding - Undetermined Site — 1 week; Diabetes — 10-20 years

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7:05 am 4/13 1967 to 7:16 pm 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rifat Abonsy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-14-67.
23C. PHYSICIAN'S NAME (Type): Rifat Abonsy M.D.
23D. ADDRESS: 1213 Light Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Balto Md 21230 Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Arlington A. Phillips
ADDRESS: 1727 N. Monroe St.

VS 150-REV. 1/1/65

1967 00037 93

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3786 Registered No. 67 3786

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John Flint Thomas

2. DATE AND HOUR OF DEATH: 4/13/1967 10 30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2522 West Pratt Street

20-04

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Single	8/10/30	36		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jesse Flint

14. MOTHER'S MAIDEN NAME: Avalan Moore

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 412-28-8023

17. INFORMANT: Alavan Flint ADDRESS: 2129 Ashburton St.

MEDICAL CERTIFICATION

18. 445 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Intracerebral Hemorrhage — 2 days

DUE TO

(B) Malignant hypertension — 2+ years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 4/11 1967 to 4/13 1967, that I (we) last saw the deceased alive on 4/13 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: S W Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type): S. W. Spaulding M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/17/67

24C. NAME of CEMETERY or CREMATORY: Ashburton Mem Pk

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Arlington A. Phillips ADDRESS: 1727 N. Monroe St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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C-540

BIRTH NO. 67 3787

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3787

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DAVID H. CONLEY

2. DATE AND HOUR PRONOUNCED DEAD: April 16, 1967 2:06 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1049 Harford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1049 Harford Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 7/4/07
9. AGE (In years last birthday): 59
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Davidson Chem.
11. BIRTHPLACE (State or foreign country): N.C
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Square Hicks
14. MOTHER'S MAIDEN NAME: Carol Conley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Margaret R. Conley
ADDRESS: 1049 Harford Av

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 4/20/67
23C. NAME of CEMETERY or CREMATORY: Mt. Calvary
23D. LOCATION (City, town, or county) (State): A.A. County, Md

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
24B. NAME OF REGISTRAR: Robert E. Fordyce
24C. FUNERAL DIRECTOR: Joseph D. Lock Jr.
ADDRESS: 1304 N. Central Ave

VS 151-REV. 1/1/65

1967 0 3795

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S-335

BIRTH NO. 67 3788

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3788

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DAVID STATON

2. DATE AND HOUR PRONOUNCED DEAD: April 16, 1967 | 10:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-02

D. STREET ADDRESS (If rural, give location): 744 Reservoir Street

5. SEX	6. RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	Negro	Married	8-7-1935	31	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Molder

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tabor, N. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Staton

14. MOTHER'S MAIDEN NAME: Maebelle Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Florine Staton ADDRESS: 744 Reservoir St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 387.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pancreatitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-29-67	Princeville	Tarbor, N. C.

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Ave.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 7 9 6

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B-510

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3789 Registered No. 67 3789

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LENA BEMBY

2. DATE AND HOUR PRONOUNCED DEAD: April 10, 1967 6:43 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 411 N. Pine Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01

D. STREET ADDRESS (If rural, give location): 411 North Pine Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	?	?	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unemployed		?	U S A

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Annie Woods ADDRESS: 413 N Pine St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease 443X

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 10, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/18/67	Mt Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 18 1967	Ralph E. Farley M.D.	Adolphus Halstead	1206 W North Ave

VS 151-REV. 1/1/65

67 003797

1

R-200

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3790 Registered No. 67 3790

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN RICE

2. DATE AND HOUR PRONOUNCED DEAD: April 14, 1967 10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

36 99 Franklin Square Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16 82

D. STREET ADDRESS (If rural, give location): 650 N. Carey Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated

8. DATE OF BIRTH: 4/12/14

9. AGE (In years last birthday): 53

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sexton

10B. KIND OF BUSINESS OR INDUSTRY: Church

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Rice

14. MOTHER'S MAIDEN NAME: Sadie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 237-18-8721

17. INFORMANT: Mr Carl Barnett ADDRESS: 641 Hillview Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 443X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 14, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/18/67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry

23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

24B. NAME OF REGISTRAR: Robert E. Faulkner

24C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

67 3790

H-4001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3791 Registered No. 67 3791

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROSE MARIE HALL

2. DATE AND HOUR OF DEATH: 4-15-67 | 10 30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital
38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 814 Monument St
D. STREET ADDRESS (If rural, give location): 10-02

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 9-11-14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sammy Ford
14. MOTHER'S MAIDEN NAME: Annie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 145.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, Metastatic, Tonsil
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 19 66 to April 15 19 67, that (I) (we) last saw the deceased alive on April 15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nelson J. Keeler Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-15-67
23C. PHYSICIAN'S NAME (Type): Nelson J. Keeler Jr. M.D.
23D. ADDRESS: Baltimore, Maryland University of Maryland Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Fankenna
25C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

3729

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300

BIRTH NO. 67 3792

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3792

1. NAME OF DECEASED (Type or Print): BOYD, BERTHA MAY

2. DATE AND HOUR OF DEATH: APRIL 17TH 1967 | 1-17 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 THE UNION MEMORIAL HOSPITAL CALVERT + 33rd BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTIMORE 9.9.C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): LITHICUM HEIGHTS 52-00

D. STREET ADDRESS (If rural, give location): 303 HAMPTON RD.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11-07-09

9. AGE (In years last birthday): 57

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): TEXAS

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: J. D. ROBERTS

14. MOTHER'S MAIDEN NAME: JENNIE GRAY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 462-36-0574

17. INFORMANT: J. PAUL BOYD ADDRESS: AS IN 4.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 571.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatic Coma

DUE TO

(B) Cirrhosis of liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from APRIL 7TH 1967 to APRIL 17TH 1967 that (I) (we) last saw the deceased alive on APRIL 17TH 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~Was~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Roy S. Patten M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: APRIL 17TH 1967

23C. PHYSICIAN'S NAME (Type): DR. ROY S. PATTEN, JR. M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL ~~THE UNION MEMORIAL HOSPITAL~~

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/67

24C. NAME of CEMETERY or CREMATORY: Van Alstyne Cemetery

24D. LOCATION (City, town, or county) (State): Van Alstyne, Texas

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Tolson

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0 3 8 0 0

D-1601

BIRTH NO. 67 3793

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3793

1. NAME OF DECEASED (Type or Print): Alice B. Deaver

2. DATE AND HOUR OF DEATH: April 16, 1967 | 10:05 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Ardleigh Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-08

D. STREET ADDRESS (If rural, give location): 2095 Rockrose Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	April 1, 1883	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: John Cason

14. MOTHER'S MAIDEN NAME: Elanor Bachelor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214-18-2255	Mr. Samuel E. Deaver Jr.	8758 Lackawanna Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Arteriosclerotic cardio-vascular disease	10 yrs.
(B) DUE TO	Rheumatoid arthritis	15 yrs.
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from August 2, 1963 to April 16, 1967, that (I) (~~we~~) last saw the deceased alive on April 12, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Apr. 18, 1967

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/19/67	Woodlawn Cemetery	Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 18 1967	Robert E. Farley M.D.	Wm. Cook-Brooks Towson	1050 York Rd. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-0001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3794

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3794

1. NAME OF DECEASED (Type or Print): CATECW, ANNA, LOUISE.

2. DATE AND HOUR OF DEATH: 4/9/67 11:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: FULL NAME OF HOSPITAL OR INSTITUTION: Maryland General Hospital (If not in hospital or institution, give street address or location) 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 8724 LOCH BEND Dr.

5. SEX: female
6. RACE: CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~Single~~ DIVORCED
8. DATE OF BIRTH: 12/13/14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10B. KIND OF BUSINESS OR INDUSTRY: appt. house.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Catecw
14. MOTHER'S MAIDEN NAME: Annie. Stansfield.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-22-5472
17. INFORMANT: admission record
ADDRESS

MEDICAL CERTIFICATION

18. 148X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma oropharynx — unknown
DUE TO: c̄ bilateral cervical metasis.

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/9 1967 to 4/9 1967, that (I) (we) last saw the deceased alive on 4/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fred R. Eilber M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/9/67
23C. PHYSICIAN'S NAME (Type): FRED R. EILBER. M.D.
23D. ADDRESS: MARYLAND GENERAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 12
24C. NAME of CEMETERY or CREMATORY: Northwood Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Frank J. Newell
ADDRESS: Pikesville, Md.

VS 150-REV. 1/1/63

J-5201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3795 Registered No. 67 3795

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JONES, VIOLA

2. DATE AND HOUR OF DEATH: 4/16/67 4:00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIV. HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: BALT
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALT 15-01
D. STREET ADDRESS (If rural, give location): 1806 N. CAREY ST

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): N
8. DATE OF BIRTH: 9/23/98
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): USA - MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SPENCER ANDERSON
14. MOTHER'S MAIDEN NAME: JOSEPHINE RANDOLPH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: PT
ADDRESS:

MEDICAL CERTIFICATION

18. 200.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PNEUMONIA — 2 days
DUE TO
(B) RETICULUM CELL SARCOMA — years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/31/67 19 to 4/16/67 19, that (I) (we) last saw the deceased alive on 4/16/67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H L Kiracofe M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): H. L. Kiracofe M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 4/21/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): Ashland Virginia

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Kaufman M.D.
25C. FUNERAL DIRECTOR: Grant Erickson
ADDRESS: 1129 N. Carey St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3796 (KATIE) Registered No. 67 3796

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Kattie Brown

2. DATE AND HOUR OF DEATH: 4/16/67 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1620-E. Monument St.

5. SEX: Female
6. RACE: Negroe
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed.
8. DATE OF BIRTH: 11/29/18
9. AGE (In years last birthday): 49 48
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S. Carolina
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry Garner
14. MOTHER'S MAIDEN NAME: Almeda Robinson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry Newman
ADDRESS: 847 Hillman Court

MEDICAL CERTIFICATION

18. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebrovascular Accident. — 1 day
DUE TO
(B) Hypertensive Arteriosclerotic
DUE TO Cardiovascular Disease
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 15, 1967 to April 16, 1967, that (I) (we) last saw the deceased alive on April 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert C. Blackmon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): Robert C. Blackmon M.D.
23D. ADDRESS: Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: April 19/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): Charleston S. Carolina

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Lashen M.D.
25C. FUNERAL DIRECTOR: Jos. T. Eckerson
ADDRESS: 1129 N. Carolina St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5.4521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3797 Registered No. 67 3797 1967

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHRISTOPHER J. SCHLANG Sr.

2. DATE AND HOUR OF DEATH: April 17, 1867 2:35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3201 Northway Drive...34

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 27-05

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3201 Northway Drive...34

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: July 17, 1887

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: Bureau of Highways

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Schlang

14. MOTHER'S MAIDEN NAME: Eli,abeth ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Christopher J. Schlang

ADDRESS: --3201 Northway Dr

MEDICAL CERTIFICATION

18. 334 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) arteriosclerotic cerebrovascular disease — 2 years

DUE TO

(B) Colostomy (for carcinoma of the rectum, cured) — 8 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from december 28 1964 to april 17 1967, that (I) (~~we~~) last saw the deceased alive on april 17 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from ~~the causes~~ stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Eleem M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): Dr. Edward J. Alessi M.D.

23D. ADDRESS: 6217 Harford Rd., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/20/67

24C. NAME of CEMETERY or CREMATORY: Western Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Tarkey M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: --5305 Harford Rd, 14

VS 150-REV. 1/1/65

0 3 8 0 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D. 260 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3798 Registered No. 67 3798

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dyser, Joseph Michael

2. DATE AND HOUR OF DEATH: April 16, 1967 | 12:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 1205
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 141 E. North Ave.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 8/29/23
9. AGE (In years last birthday): 43
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouseman
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Joseph Dyser
14. MOTHER'S MAIDEN NAME: Stacia Barrick

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 2/22/43-2/7/46
16. SOCIAL SECURITY NO.: 216-12-51-60
17. INFORMANT: Records
ADDRESS: Veterans Administration Hospital, Balto., Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 198.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Retroperitoneal lymphoma — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 3/29/67 & 4/10/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Retroperitoneal lymphoma
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 27, 1967 to April 16, 1967, that (I) (we) last saw the deceased alive on April 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Victor Velez Jr Borges M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: April 17, 1967
23C. PHYSICIAN'S NAME (Type): VICTOR V. J. BORGES M.D.
23D. ADDRESS: Veterans Hospital, Balto., Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: Baltimore Nat'l Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc
ADDRESS: Baltimore, Md.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

15.465

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3799 Registered No. 67 3799

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rosalie Salerno

2. DATE AND HOUR OF DEATH: 4-17-67 | 5 15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Catonsville 53-00
D. STREET ADDRESS (If rural, give location): 5412 channing Rd - 21229

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 10/24/XX 1886
9. AGE (In years last birthday): ~~XX~~ 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Trapani
14. MOTHER'S MAIDEN NAME: Carlo

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Jennie Salino — ADDRESS: 5412 Channing Rd. - 21229

MEDICAL CERTIFICATION

1B. 3 3 1 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebrovascular hemorrhage

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-14-1967 19 to 4-17 19 67, that (I) (we) last saw the deceased alive on 4-17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jung Kook Lee M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 17, 1967
23C. PHYSICIAN'S NAME (Type): Jung Kook Lee M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: Lorraine Pk. Mausoleum
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave. — ADDRESS

VS 150-REV. 1/1/65

1967 B 0 0 3 8 0 7

N550/5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3800 Registered No. 67 3800

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Newman, Annetta

2. DATE AND HOUR OF DEATH: 4/16/67 6:15 PM

CERTIFICATE AMENDED 4-20-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto C
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 115 North Beechwood Ave.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 6/21/1887
9. AGE (In years last birthday): 79 — If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore MD
12. CITIZEN OF WHAT COUNTRY? U S A.
13. FATHER'S NAME: Joseph Horwitz
14. MOTHER'S MAIDEN NAME: Scheain
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-01-6136
17. INFORMANT: ~~Mrs. Raymond Fink, Sr. 607 Braeside Rd. - 21229~~ Mrs. Leonard Fink — ADDRESS: 115 N. Beechwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — years
DUE TO
(B) Arteriosclerotic heart disease — years
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 15th April 1967 to 16th April 1967, that (I) (we) last saw the deceased alive on 16th April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Z R Park M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): Zal Rok Park M.D.
23D. ADDRESS: Bon Secours Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave. — ADDRESS

VS 150-REV. 1/1/65

3808

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K 450 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3801 Registered No. 67 3801

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Emma Killen

2. DATE AND HOUR OF DEATH: April 17, 1967 | 8:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

CERTIFICATE AMENDED

(If in a hospital or institution, give name of hospital or institution; if not in hospital or institution, give street address or location)

4-20-67

1505 Ramsay Street
Balto., 23, Md.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Baltimore, Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1903

D. STREET ADDRESS (If rural, give location): 1505 Ramsay Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F.	Cauc.	Widowed ~~Married~~	9/13/87	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - --- Martynn

14. MOTHER'S MAIDEN NAME: Late ~~Olida~~ Otilda

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. John J. Killen — ADDRESS: 1505 Ramsay St.

MEDICAL CERTIFICATION

I

1B. 466 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary embolism 1h

DUE TO

(B) Phlebothrombosis

DUE TO

(C) —

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 15 1967 to April 15 1967, that (I) (we) last saw the deceased alive on April 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): George Vash M.D.

23D. ADDRESS: 204 S. Gilmor St. - 21223

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-20-67	New Cathedral Cem.	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave. — ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

V.S. 153 4-20-67 M.H.

R 245 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3802 Registered No. 67 3802

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bessie M. Reuschlein

2. DATE AND HOUR OF DEATH: Apr. 15, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

90 Hodd Convalescent Home
5313 Edmondson Avenue
Baltimore, Maryland, 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: HOWARD Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Baltimore~~ ELLICOTT CITY 63-00

D. STREET ADDRESS (If rural, give location): 214 RAMSEY DRIVE ~~633 Linnard Street, zone~~ 29

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Sept. 7, 1878

9. AGE (In years last birthday): 88

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Wolfe

14. MOTHER'S MAIDEN NAME: Susan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-54-6647

17. INFORMANT: Mrs. Clinton L. Ewing, 214 Ramsey Dr., Ellicott City, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443X I 421X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebro vascular accident — 7 d

DUE TO

(B) ASCVD x hypertension — 20 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma cervix — 10 yrs

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1 January 1960 to 15 April 1967, that (I) (we) last saw the deceased alive on 14 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: James E. Rowe M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): James E. Rowe M.D.

23D. ADDRESS: 5550 Baltimore National Pike, Balto. Md., 21228

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 18, 1967

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md., 21207

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md., 21043

VS 150-REV. 1/1/65

1 7 6 7 0 0 3 8 1 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

44-33-90 TN

R300

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67, 3803 Registered No. 67 3803

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Reid, Alice

2. DATE AND HOUR OF DEATH: 4/15/67 6 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31 Balto City Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 703

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 613 N. BRADFORD STREET 21205

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 11-16-86

9. AGE (In years last birthday): 80

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerry COMER

14. MOTHER'S MAIDEN NAME: Hardin TRUDY Suker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: BCH: RECORDS 4940 EASTERN AVE. BALTO. MD. 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. 493X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — 3 days

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA — 1 3/4 yrs

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/13 1965 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Mary Ann Sullivan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): DR. MARY ANN SULLIVAN M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-19-67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Fashman

25C. FUNERAL DIRECTOR: Thos O. Wilson and Brantley Co

ADDRESS:

VS 150-REV. 1/1/65

3

1

M. 600

BIRTH NO. 67 3804

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3804

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT E. MOORE JR

2. DATE AND HOUR PRONOUNCED DEAD: 4-16-67 12:01 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): JOHNS HOSPKINS HOSPITAL - DOA

33/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06
D. STREET ADDRESS (If rural, give location): 1500 N. Durham Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	single	2-23-1941	26				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales		Baltimore Md	U S A

13. FATHER'S NAME: Robert Moore Sr

14. MOTHER'S MAIDEN NAME: Louise Byrd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): N

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert Moore Sr ADDRESS:

MEDICAL CERTIFICATION

1B. 2982

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive internal bleeding

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Stab wound of chest involving heart

DUE TO XXXX

(C) and lung

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Wolfe Street - 100 ft. N. of Preston Street 8-07

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 15 (Year) '67 (Hour) 11:35 PM m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Unknown - Found on sidewalk

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-20-67

23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

24B. NAME OF REGISTRAR: Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR: Elroy Wilson von Brantley Sr

ADDRESS:

VS 151-REV. 1/1/65

N 879.4 1 9 6 7 0 0 3 8 1 3

P 6601

45 57 89 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3805

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3805

1. NAME OF DECEASED (Type or Print): Pryor James

2. DATE AND HOUR OF DEATH: 4/17/67 | 7 45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 6-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1904 Orleans Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: 12/9/96

9. AGE (In years last birthday): 70 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James

14. MOTHER'S MAIDEN NAME: Rebecca Stewart

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 581.01 + 177 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Liver Failure — 2 yrs.

DUE TO

(B) Cirrhosis of the Liver — 5 yrs.

DUE TO

(C) Carcinoma of Prostate — 5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Poss. Pulm. Embolus Gram Neg. Sepsis

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 4/8 19 67 to 4/17 19 67, that (I) (we) last saw the deceased alive on 4/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C H Brown III M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): C. H. Brown, III M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-67

24C. NAME of CEMETERY or CREMATORY: Mt Cahary Cem

24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE RECEIVED BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Helen E. Tarkey MA

25C. FUNERAL DIRECTOR: Elroy Wilson ADDRESS: 1001 Brenton Md

VS 150-REV. 1/1/65

1967 0 0 3 8 0 5

B-620

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3806 Registered No. 67 3806

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARGIE BIRCH

2. DATE AND HOUR PRONOUNCED DEAD: April 16, 1967 9:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 502
D. STREET ADDRESS (If rural, give location): 578 N. Gay Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: March 23 1913
9. AGE (In years last birthday): 53
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cabot Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Coates
14. MOTHER'S MAIDEN NAME: Heather Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Beverly Long ADDRESS: 9132 Chase St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. E900.0 + 322.0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spinal cord injury

DUE TO

(B) Fracture of cervical spine

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Acute ethylism

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 578 N. Gay Street 502

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): bet. 4-15 (or) 11:15P; 4-16 " 2:15 Am.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Apparently fell down steps

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-20-67
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Cem.
23D. LOCATION (City, town, or county) (State): Arbutus, Md

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Elroy O Wilson
ADDRESS: 1000 Brantly Ln

VS 151-REV. 1/1/65

N80ST 0 0 0 3 8 1 4

P-536

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3807 Registered No. 67 3807

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PINDER, Louis (NMI)

2. DATE AND HOUR OF DEATH: April 16, 1967 1:35 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218
27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 2007
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 504 Normandy Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12/22/22
9. AGE (In years last birthday): 44
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: City of Balto.
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Pinder
14. MOTHER'S MAIDEN NAME: Pearl Lee

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): 6-25-42 to 10-1-43
16. SOCIAL SECURITY NO.: 214-14-9507
17. INFORMANT: Records
ADDRESS: Veterans Administration Hosp. Balto., Md.

MEDICAL CERTIFICATION

18. 165X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH: Bronchopneumonia due to terminal lung CA
(A) DUE TO
(B) DUE TO
(C)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from April 16 1967 to April 16 1967, that (X) (we) last saw the deceased alive on April 16 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sung ill Shin
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X
23B. DATE SIGNED: 4-16-67
23C. PHYSICIAN'S NAME (Type): Sung ill Shin M.D.
23D. ADDRESS: 3900 Loch Raven Blvd. Baltimore Maryland 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: Balto Nat Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Eloy O Wilson
ADDRESS: 1000 Brantly Rd

VS 150-REV. 1/1/65

1967 00 0 3 8 1 5

W-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3808 Registered No. 67 3808

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Wallace

2. DATE AND HOUR OF DEATH: 4/12/67 | 12 50 Noon

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2007 North Pulaski Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12/23/17
9. AGE (In years last birthday): 49 ~~yrs~~ | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic Work
10B. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lee
14. MOTHER'S MAIDEN NAME: Bessie Murray

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Samuel Wallace
ADDRESS: 2007 N. Pulaski St.

MEDICAL CERTIFICATION

1B. 330 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Subarachnoid Hemorrhage — 4 days
(B) DUE TO: Hypertension — years
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 4/8 1967 to 4/12 1967, that I (we) last saw the deceased alive on 4/12 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) ~~not~~ view the body after death.

23A. SIGNATURE: S W Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/12/67
23C. PHYSICIAN'S NAME (Type): S. W. Spaulding M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/17/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore CO. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Herbert E. Nutter
ADDRESS: 305 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0 0 0 3 8 1 6

M-435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3809 Registered No. 67 3809

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Milton Susan Shaw

2. DATE AND HOUR OF DEATH: 4-15-67 | 7:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1736 Ashburton St. #16

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	married	9/26/1898	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S. Stephens S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Louise Hollman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Milton ADDRESS: 1736 Ashburton

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) 420.1 CIRCULATORY COLLAPSE — ACUTE

DUE TO

(B) ACUTE MYOCARDIAL INFARCTION

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-15 1967 to 4-15 1967, that (I) (we) last saw the deceased alive on 4-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Renato R. Espina, M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-15-67

23C. PHYSICIAN'S NAME (Type): RENATO R. ESPINA M.D.

23D. ADDRESS: LUTH. HOSP. OF MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/18/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE RECD BY HEALTH DEPT. APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Fayle MD

25C. FUNERAL DIRECTOR: Maurice Rotz

ADDRESS: 638 [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

67 003817

1

5-134

67 3810

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 3810

BIRTH NO.

M.E. CASE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES LINWOOD SPIDELL, Sr.

2. DATE AND HOUR PRONOUNCED DEAD: 4-15-67 8:37 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: JOHNS HOPKINS HOSPITAL - DOA

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

6-02

D. STREET ADDRESS (If rural, give location): 239 N. Milton Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: DEC. 6, 1926

9. AGE (In years last birthday): 40

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELMER V. SPIDELL

14. MOTHER'S MAIDEN NAME: HAZEL M. RITENOUR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES. (If yes, give war or dates of service): W.W. II

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Hazel M. Hefner

ADDRESS: 2315 Anoka Ave. 21215

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): ~~Yes~~ no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 4-19-67

23C. NAME of CEMETERY or CREMATORY: BALTO. NATIONAL CEM.

23D. LOCATION (City, town, or county) (State): BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

24B. NAME OF REGISTRAR: Robert E. Farley

24C. FUNERAL DIRECTOR: Hartley Miller

ADDRESS: 2334 Jefferson St.

VS 151-REV. 1/1/65

L 67 000 3810

B-451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3811 Registered No. 67 3811

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BLANKENSHIP, WALLACE A.

2. DATE AND HOUR OF DEATH: April 7, 1967 - 12:15 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital. Baltimore 5, Md.

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: CECIL Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELKTON 59-00

D. STREET ADDRESS (If rural, give location): P.O. BOX 461

5. SEX: Male. 6. RACE: White. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married.

8. DATE OF BIRTH: 8-22-23 9. AGE (In years last birthday): 43

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Chrysler Corp.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: CYNTHIA BLANKENSHIP

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 231-12-7702

17. INFORMANT: Mrs. Mae Blankenship, Elkton, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypernephroma (R) kidney. DUE TO — INTERVAL BETWEEN ONSET AND DEATH: About 7 months

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/20/67 & 3/14/67. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ① Hypernephroma ② Pain.

20A. AUTOPSY? (Yes or No): YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from March 14, 1967 to April 7, 1967, that (I) (~~we~~) last saw the deceased alive on April 7, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C Bhushan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: April 7, 1967.

23C. PHYSICIAN'S NAME (Type): CHHABI BHUSHAN. M.D.

23D. ADDRESS: The Johns Hopkins Hospital, Baltimore 5, Maryland.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/12/67

24C. NAME of CEMETERY or CREMATORY: Gilpin Manor Memorial Park, Elkton, Md.

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Falkenna

25C. FUNERAL DIRECTOR: Ralph E. Hicks

ADDRESS: Hicks Home for Funerals, Elkton, Md.

VS 150-REV. 1/1/65

6 0 3 8 1 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-525

BIRTH NO. 67 3812

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3812

1. NAME OF DECEASED (Type or Print): Charles Vincent

2. DATE AND HOUR OF DEATH: 4/18/67 | 630 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 213 North Kenwood Avenue

6-01

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 11/03/14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lens grinder
10B. KIND OF BUSINESS OR INDUSTRY: Self-employed
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Vincent
14. MOTHER'S MAIDEN NAME: Irene Oliver

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes
(If yes, give war or dates of service): WW11
16. SOCIAL SECURITY NO.: 215-09-7002
17. INFORMANT: Mrs. Loretta A. Vincent
ADDRESS: 213 N. Kenwood Ave

MEDICAL CERTIFICATION

1B. 163 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Lung Cancer
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: 6 months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 4/14 19 67 to 4/18 19 67, that I (we) last saw the deceased alive on 4/18 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: SW Spaulding
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): S. W. Spaulding M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/21/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Tankersley
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Baltimore St.

VS 150-REV. 1/1/65

67 003810

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-263

BIRTH NO. 67 3813

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3813

1. NAME OF DECEASED (Type or Print): Haggerty, James V.

2. DATE AND HOUR OF DEATH: April 16th 1967. 4:15 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Howard

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Ellicott city 63-00

D. STREET ADDRESS (If rural, give location): 801 E. Staymad Dr. STAMIN

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 8/25/10

9. AGE (In years last birthday): 56

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: U.S. Govt

11. BIRTHPLACE (State or foreign country): N.Y

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: John J. Haggerty.

14. MOTHER'S MAIDEN NAME: Margaret Ann Quinn

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-42-6054

17. INFORMANT: MARGARET F. HAGGERTY

ADDRESS: SAME AS #4

MEDICAL CERTIFICATION

18. 5811 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Massive GI Hemorrhage

DUE TO

(B) Laennec's cirrhosis, liver 1 year

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 14th March 1967 to 16th April 1967, that (I) (we) last saw the deceased alive on 16th April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B R Park M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/16/1967

23C. PHYSICIAN'S NAME (Type): SAI ROK PARK M.D.

23D. ADDRESS: Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/67

24C. NAME of CEMETERY or CREMATORY: Mt Olivet

24D. LOCATION (City, town, or county) (State): Washington D.C

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Fabian

25C. FUNERAL DIRECTOR: Francis J. Collins

ADDRESS: 3821-14th St N.W Wash

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3814 Registered No. 67 3814

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOLLAND, ROBERT E.

2. DATE AND HOUR OF DEATH: 4/16/67 9 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 5811 BLAND AVE

5. SEX: M

6. RACE: CAU

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 3/7/28

9. AGE (In years last birthday): 39

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10B. KIND OF BUSINESS OR INDUSTRY: Electrical Contracting

11. BIRTHPLACE (State or foreign country): MD. Baltimore

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CHARLES HOLLAND

14. MOTHER'S MAIDEN NAME: Amandia Weber

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): 1951-53

16. SOCIAL SECURITY NO.: 214-24-3946

17. INFORMANT: WIFE

ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MENINGITIS

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): None

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 4/13/67 19 to 4/16/67 19, that (I) (we) last saw the deceased alive on 4/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Brett Lazar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/16/67

23C. PHYSICIAN'S NAME (Type): J. BRETT LAZAR M.D.

23D. ADDRESS: Sinai Hospital of Balt.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/20/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Vernon Lemmon

ADDRESS: 4611 Park Heights Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-07-61 GG R-550

BIRTH NO. 67 3815

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3815

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): CARL ROMANO

2. DATE AND HOUR OF DEATH: APRIL 14 1967 1:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE 21224, MARYLAND
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE # 21221 53-00
D. STREET ADDRESS (If rural, give location): 1618 Doolittle Road

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11-26-94
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CAB DRIVER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Salvatore
14. MOTHER'S MAIDEN NAME: Philomenia

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 058-14-8984
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue # 21224
ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIAC ARREST — 1½ hours

DUE TO

(B) MYOCARDIAL INFARCTION — UNKNOWN.

DUE TO

(C) ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14 1967 to 4/14 1967, that (I) (we) last saw the deceased alive on 4/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. Tarsy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): Dr. H. Tarsy M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Avenue #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: BALTO. NAT.
24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Lankey M.D.
25C. FUNERAL DIRECTOR: J. H. Connolly Son
ADDRESS: 300 Mace

VS 150-REV. 1/1/65

P-412

BIRTH NO. 67 3816

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3816

1. NAME OF DECEASED (Type or Print): MINION Lauretta PHILLIPS

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annapolis 52-10
D. STREET ADDRESS (If rural, give location): 8 Morris Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2-12-1910
9. AGE (In years last birthday): 57
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: *******
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William McPherson
14. MOTHER'S MAIDEN NAME: Hattie McGowan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ********
16. SOCIAL SECURITY NO.: 214-24-8001
17. INFORMANT: Benjamin Phillips
ADDRESS: 8 Morris St Anna.Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E953X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sickle Cell Crisis (SA Hemoglobinopathy)
DUE TO
(B) Congestive Heart Failure (Acute and Chronic)
DUE TO
(C) Intravenous Inulin and Dextrose.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriolar Nephrosclerosis.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Johns Hopkins Hospital 7-05

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 12 (Year) '67 (Hour) P m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Intravenous administration of Inulin and Dextrose for kidney function studies.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4/13/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-15-1967
23C. NAME of CEMETERY or CREMATORY: Brewer Hill
23D. LOCATION (City, town, or county) (State): Annapolis, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
24B. NAME OF REGISTRAR: Robert E. Faulkner
24C. FUNERAL DIRECTOR: C.E.Hicks,III
ADDRESS: Annapolis,Md

VS 151-REV. 1/1/65 N 999129670003824

T-6101

Anne Arundel Co., Md.

BIRTH NO. 67 3817

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 3817

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): TERSHIA JENINCEE THORPE

2. DATE AND HOUR OF DEATH: 4/13/67 | 6:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: Anne Arundel Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Annapolis 21401
D. STREET ADDRESS (If rural, give location): 14 Bunche St. 52-10

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 11/08/66
9. AGE (In years last birthday): If Under 1 Yr. Months: 5 | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: James Thorpe
14. MOTHER'S MAIDEN NAME: Pauline Cramer
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: James A. Thorpe
ADDRESS: Annapolis, Md 14 Bunche Street

MEDICAL CERTIFICATION

I

1B. 7 5 4 4

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Endocardial Fibroelastosis
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/3 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Elizabeth Maxwell M.O.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/13/67
23C. PHYSICIAN'S NAME (Type): ELIZABETH MAXWELL [redacted] M.O.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-16-67
24C. NAME of CEMETERY or CREMATORY: PINE LAWN
24D. LOCATION (City, town, or county) (State): ANNAPOLIS Md

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: C. E. HICKS III
ADDRESS: ANNAPOLIS, Md

VS 150-REV. 1/1/65

3 8 2 5

F-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3818

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3818

1. NAME OF DECEASED (Type or Print): Mary E. Frampton.

2. DATE AND HOUR OF DEATH: April 16, 1967 12:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: A.A. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena. 52-00
D. STREET ADDRESS (If rural, give location): 1428 Thies Dr. Hunter Harbor

5. SEX: F.
6. RACE: White.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow.
8. DATE OF BIRTH: 11-12-88
9. AGE (In years last birthday): 78.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: None.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rubin Kimball
14. MOTHER'S MAIDEN NAME: Amelia Roehmer.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-01-2893
17. INFORMANT: Mrs. E. Hines ADDRESS: 1428 Theis Dr. Pasadena, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 442 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) UREMIA
DUE TO
(B) Nephrosclerosis
DUE TO
(C) ASCVD and CHF

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 22
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-14 19 67 to 4-16 19 67, that (I) (we) last saw the deceased alive on 4-16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Gary A. Fleming M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-17-67.
23C. PHYSICIAN'S NAME (Type): Gary A. Fleming M.D.
23D. ADDRESS: 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: Louden Park Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: McCully- 130 E. Fort Ave. Balto. Md. ADDRESS

VS 150-REV. 1/1/65

1967 0 0 3826

H-346

BIRTH NO. 67 3819

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3819

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Henry L. Haetler

2. DATE AND HOUR OF DEATH: 4/16/67 | 5:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 2410 Halcyon Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Feb. 4, 1893
9. AGE (In years last birthday): 74
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10B. KIND OF BUSINESS OR INDUSTRY: Western Md. Dairy
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Haetler
14. MOTHER'S MAIDEN NAME: Anna Schmidt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-10-2718
17. INFORMANT: Mildred E. Haetler
ADDRESS: 2410 Halcyon Avenue-21214

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute anteroseptal myocardial infarction — 5 days

DUE TO

(B)

DUE TO

(C) ASCVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11 1967 to 4/16 1967, that (I) (we) last saw the deceased alive on 4/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis E. Grenzer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Faber, M.D.
25C. FUNERAL DIRECTOR: John C. Miller Inc.
ADDRESS: 6415 Belair Road-21206

VS 150-REV. 1/1/65

1967 0 3827

40-77-64 GG1 G-164 67 3820

BIRTH NO. 67 3820

M.E. CASE NO. ~~GABRIEL~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3820

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): GABRIEL John

2. DATE AND HOUR OF DEATH: 4/15/67 | 10:05 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE 21224, MD. 31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21202
D. STREET ADDRESS (If rural, give location): 40 Fremont Avenue 18-01

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Divorced	11-16-08	59		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cement Finisher	Balto., City	MARYLAND	U.S.A.

13. FATHER'S NAME: Stanley Gabriel

14. MOTHER'S MAIDEN NAME: Anna Stanilous

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS: BCH 4940 Eastern Ave. #21224 — ADDRESS

MEDICAL CERTIFICATION

1B. 570.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Shock.
DUE TO
(B) Septicemia
DUE TO
(C) GANGRENE of Bowel

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: ① 3/21/67 ② 4/10/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ① Esophageal stricture ② Mechanical Ileus

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/14/66 to 4/15/67, that (I) (we) last saw the deceased alive on 4/15/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo Trefogli M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): PABLO TREFOGLI M.D.

23D. ADDRESS: BCH 4940 Eastern Ave. #21224

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/18/67	Holy Redeemer Cemetery	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Lahey M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, 3331 Brehms Lane #13 — ADDRESS

VS 150-REV. 1/1/65

3820

H-160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3821 Registered No. 67 3821

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Hoover Mr. Charles E.

2. DATE AND HOUR OF DEATH: 15 April 1967 | 2:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home a Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 4501 Freedom Way West #13

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 2-17-17

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Harrison Wood Floors

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Hoover

14. MOTHER'S MAIDEN NAME: Hilda Davis (nee Hum)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 218-03-1353

17. INFORMANT: Doris Hoover, wife, above ADDRESS

MEDICAL CERTIFICATION

1B. 540.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest

DUE TO

(B) Perforated Peptic Ulcer

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4/13/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gastrointestinal Bleeding

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-12-67, 19 to 4/15 1967, that (I) (we) last saw the deceased alive on 15 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Allan Freeman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-15-67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home

ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

000 3829

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3822 Registered No. 67 3822

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUTH A. GLATZELL

2. DATE AND HOUR OF DEATH: April 13, 1967 8 p. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3013 E. Monument St. Baltimore, Md., 21205

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Md., 21205
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3013 E.Monument St.

1-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	married	4/14/05	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales	Woolworth's	Wheeling, W. Va.	

13. FATHER'S NAME: John T. Dorff

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Herbert Glatzell, husband, above ADDRESS

MEDICAL CERTIFICATION

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Nephrosclerosis with Uremia — 5 yrs.

DUE TO

(B) Diabetes Mellitus — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 1959 to April 13 1967, that (I) (~~we~~) last saw the deceased alive on April 12 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Clarence W. LeDoux M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): Dr.Clarence LeDoux M.D.

23D. ADDRESS: 3023 Eastern Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/17/67	Gardens of Faith Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Fischer M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

3830

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-35 b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3823 Registered No. 67 3823

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARTHA MARGARET STEINMETZ

2. DATE AND HOUR OF DEATH: April 13, 1967 | 2A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 607 S. Linwood Ave. Baltimore, Md., 21224

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Md. 21224

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1-02

D. STREET ADDRESS (If rural, give location): 607 S. Linwood Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	married	7/9/1887	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife	at home	Baltimore, Md.	

13. FATHER'S NAME: William Talley

14. MOTHER'S MAIDEN NAME: Frances Boyce

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 717-07-8449B

17. INFORMANT: Elmer F. Steinmetz, husband, above ADDRESS:

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cut Sd C-V, disease

DUE TO Anemia & decompensation

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 19 67 to 4/13 19 67, that (I) (we) last saw the deceased alive on 4/11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Julius H Goodman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): Dr. Julius H. Goodman M.D.

23D. ADDRESS: 3400 E. Baltimore St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/17/67	Schwartz Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 2601 E. Madison St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-635

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3824 Registered No. 67 3824

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John C. Barton

2. DATE AND HOUR OF DEATH: April 16, 1967 | 12 45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1022 E. 36th St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-03
D. STREET ADDRESS (If rural, give location): 1022 E. 36th St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10/17/1902
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass't. Super. Construction
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur P. Barton
14. MOTHER'S MAIDEN NAME: Rebecca Noon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-10-8838
17. INFORMANT: Mrs. Marion D. Barton
ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 260X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) arteriosclerotic Hypertensive — 5 yrs
DUE TO
cardio vascular disease
(B)
DUE TO
(C) Diabetes mellitus - mild — 3 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 19 61 to Apr 16 19 67, that (I) (~~we~~) last saw the deceased alive on March 3 19 67 and that in (~~my~~) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: George D. Lippy M.O. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): George D. Lippy M.O.
23D. ADDRESS: 426 S. Patterson Park Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Mem. Pk.
24D. LOCATION (City, town, or county) (State): Elkridge, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farkas MD
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

1967 0 0 3 8 3 2

G-452

BIRTH NO. 67 3825

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3825

1. NAME OF DECEASED (Type or Print): Julia K. Glinski

2. DATE AND HOUR OF DEATH: April 16 1967 5:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 6609 O"Donnell Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-36

D. STREET ADDRESS (If rural, give location): 6609 O"Donnell Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	Married b	Sept 9-1895	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
house-wife	home	Poland	U.S.A.

13. FATHER'S NAME: Andrew Wiech

14. MOTHER'S MAIDEN NAME: Carolin Szuba

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-1001B

17. INFORMANT: Daniel Glinski 6609 O"Donnell Street — ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 42011 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Coronary Thrombosis

DUE TO

(B) Hypertensive C.V. Disease — 1958

DUE TO

(C) Acute Pleurisy — 1 week

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 58 to April 16 19 67, that (I) (we) last saw the deceased alive on April 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stephen C. Mackowiak M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-17-67

23C. PHYSICIAN'S NAME (Type): STEPHEN C. MACKOWIAK M.D.

23D. ADDRESS: 6714 HARBIRD AV. Baltimore Md 21222

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-20-67	Sacred Heart of Mary	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Fagan

25C. FUNERAL DIRECTOR: Walter Dabrowski — ADDRESS: 1005 Dundalk Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-1210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3826 Registered No. 67 3826

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARIE DAVIS

2. DATE AND HOUR OF DEATH: 4-15-67 12:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-09

D. STREET ADDRESS (If rural, give location): 1507 LAMONT AVE

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: 11-30-93

9. AGE (In years last birthday): 73

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): alabama

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: THOMAS VALE

14. MOTHER'S MAIDEN NAME: SARAH JONES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Curtis Douglas

ADDRESS: 1507 Lamont ave

MEDICAL CERTIFICATION

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarct — 8 hrs

DUE TO

(B) arteriosclerosis — years

DUE TO

(C) Diabetes mellitus — 10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obesity — years

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/15 1967 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harmon J Eyre M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): Harmon J Eyre M.D.

23D. ADDRESS: 601 North Broadway Balt. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/20/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. PK

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Fulgham

25C. FUNERAL DIRECTOR: Wm. L. Whitmanp

ADDRESS: 1701 McCulloh St

3 8 3 4

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was the regular attendant on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3827 Registered No. 67 3827

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): McDONALD, JOHN

2. DATE AND HOUR OF DEATH: 4/18/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-38
D. STREET ADDRESS (If rural, give location): 3507 LIBERTY HEIGHTS AVE #16

5. SEX: M
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): (circled) MARRIED
8. DATE OF BIRTH: 9/15/06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JANITOR
10B. KIND OF BUSINESS OR INDUSTRY: PEABODY CONS.
11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ed McDONALD
14. MOTHER'S MAIDEN NAME: LOUELLA WHITE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-01-5150
17. INFORMANT: HENRIETTA McDONALD ADDRESS: 3502 LIBERTY HGTS

MEDICAL CERTIFICATION

1B. 239 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) GI BLEEDING — 3 days
DUE TO
(B) ? CVA — 3 days
DUE TO
(C) ? INTRAABDOM. TUMOR — 1 months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/16/1967 to 4/18/1967, that (I) (we) last saw the deceased alive on 4/18/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hyman Greenfield M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): HYMAN GREENFIELD M.D.
23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/22/67
24C. NAME of CEMETERY or CREMATORY: MT AUBURN
24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Ralph E. Falkenhan
25C. FUNERAL DIRECTOR: Morris R. Hayes ADDRESS: 1355 N GILMOR ST

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-241

BIRTH NO. 67 3828

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3828

1. NAME OF DECEASED (Type or Print): ERNEST MC ELEVEEN or McElveen Wilbur

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 | 10:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home & Hospital (DOA)

35/39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 1729 E. Baltimore Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 31, 1898
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Labor
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City
11. BIRTHPLACE (State or foreign country): Lake City S.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk Mc Elveen
14. MOTHER'S MAIDEN NAME: Charlotte Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World War ~~II~~ 1
16. SOCIAL SECURITY NO.: 220-07-8020
17. INFORMANT: Alice C. McElveen
ADDRESS: 1729 E Baltimore Street

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I

18. 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: April 14, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Apr 19 1967
23C. NAME of CEMETERY or CREMATORY: St Paul Cemetery .
23D. LOCATION (City, town, or county) (State): 5600 Cardiff Avenue Md

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Fahrney
24C. FUNERAL DIRECTOR: Dippel Brothers Inc
ADDRESS: 1800 E Lombard Street

VS 151-REV. 1/1/65

967000 3836

P-420

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3829

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3829

1. NAME OF DECEASED (Type or Print): Pawlak Gertrude GERTRUDE R. PAWLAK

2. DATE AND HOUR OF DEATH: 8:20 PM 4/15/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland Geri Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 9-05
D. STREET ADDRESS (If rural, give location): 3204 Ellerslie Ave

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3/17/99
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Balto Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Nehring Peter Nehring
14. MOTHER'S MAIDEN NAME: Katherine Piechocki Katherine Piechocki

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): -
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 215091891
17. INFORMANT: Chart
ADDRESS: Miss Marie Nehring, 3204 Ellerslie Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 722.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Severe rheumatoid arthritis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Upper GI bleeding

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11 1967 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel Cullkum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/15/67
23C. PHYSICIAN'S NAME (Type): Daniel C Wilkerson M.D.
23D. ADDRESS: 421 Register Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus
24D. LOCATION (City, ~~Town, or County~~) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Fagley M.D.
25C. FUNERAL DIRECTOR: Sadowski Funeral Home
ADDRESS: 1808 Eastern Ave.

VS 150-REV. 1/1/65 1967 M. F. SADOWSKI & SONS, 1808 EASTERN AVE

P-4121

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3830 Registered No. 67 3830

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Annie Phelps

2. DATE AND HOUR OF DEATH: 4/14/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION: 00 — (If not in hospital or institution, give street address or location): 402 Sanders St Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 24-02
D. STREET ADDRESS (If rural, give location): 402 Sanders St 21230

5. SEX: Female
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Oct 17, 1887
9. AGE (In years last birthday): 79
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Thomas Shea
14. MOTHER'S MAIDEN NAME: Mary Ann O Brien

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family ADDRESS: Same

MEDICAL CERTIFICATION

18. 492X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: (A) Virus pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized arteriosclerosis

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1965 to April 13 1967, that (I) (we) last saw the deceased alive on April 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Romulo V. Coco M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): Romulo V. Coco M.D.
23D. ADDRESS: 5500 Bowleys Lane

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cem
24D. LOCATION (City, town, or county) (State): A A Co Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: McCully, F H
ADDRESS: 130 E Fort Ave 21230

VS 150-REV. 1/1/65

67 3830

G-61 B

BIRTH NO. 67 3831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3831

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRAVATT, ESTHER WELLS

2. DATE AND HOUR OF DEATH: 4/18/67 | 1 40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Chas. Gen Hosp. 49 2724 N. Chas. ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2748
D. STREET ADDRESS (If rural, give location): 906 Dartmouth Rd - 21212

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 4/6/04
9. AGE (In years last birthday): 63
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: Jacob Readwells
14. MOTHER'S MAIDEN NAME: Ida Rogers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Susan R. O'Donnell / F. Chari ADDRESS: 906 DartmouthRd.

MEDICAL CERTIFICATION

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infect — week
DUE TO
(B) Coronary artery dis — yr.
DUE TO
(C) Diabetis m. = acidosis — yrs & days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-18 1967 to 4-18 1967, that (I) (we) last saw the deceased alive on 4-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-18-67.
23C. PHYSICIAN'S NAME (Type): E. Ellsworth Cook M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial
24D. LOCATION (City, town, or county) (State): Baltimore County, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Fogleman
25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home
ADDRESS: 6500 York Rd. Balto., Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-416

BIRTH NO. 67 3832

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3832

1. NAME OF DECEASED (Type or Print): Ella S. Coulbourn

2. DATE AND HOUR OF DEATH: April 13, 1967 8 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4407 Marble Hall Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2709

D. STREET ADDRESS (If rural, give location): 4407 Marble Hall Rd.

5. SEX: Male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 4-29-1901

9. AGE (In years last birthday): 65

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME: Ernest W. Gresham

14. MOTHER'S MAIDEN NAME: Nellie P. Chilton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Samuel H. Coulbourn ADDRESS: 4407 Marble HallRd

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Occlusion — 4 hours

DUE TO

(B) Hypertensive CV Disease — 15 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 1950 to April 13 1967, that (I) (~~we~~) last saw the deceased alive on April 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: A. Allan Spier M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type): Dr. A. Allan Spier M.D.

23D. ADDRESS: 1501 Pentridge Rd.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE:

24C. NAME of CEMETERY or CREMATORY: St. Mary's White Chapel

24D. LOCATION (City, town, or county) (State): Ch. Cem. Lively, Va.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Fairbairn

25C. FUNERAL DIRECTOR: Elmore-Haynie Funeral Home ADDRESS: Kilmarnock, Va.

VS 150-REV. 1/1/65

1967 0 0 3 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-625

BIRTH NO. 67 3833

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3833

1. NAME OF DECEASED (Type or Print): Clara H. Kirkner

2. DATE AND HOUR OF DEATH: April 16, 1967 9:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 1105 E. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 5-01

D. STREET ADDRESS (If rural, give location): 1105 E. Fayette Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Never Married	8-17-1882	84				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nurse	Nursing	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Edward Kirkner

14. MOTHER'S MAIDEN NAME: Catherine Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212 26 8004A

17. INFORMANT: Mrs. Tomassia ADDRESS: Perry Hall 21128 30 Bangert Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Dis Sev yrs — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diverticulosis ~~XX~~. Sigmoid Colon — 10 yrs.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~XXXXXXX~~) attended the deceased from 9-27 1954 to 4-16 1967, that (I) ~~XX~~ last saw the deceased alive on 4-15 1967 and that in (my) (~~XX~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~X~~) (did) (~~XXXX~~) view the body after death.

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐

23B. DATE SIGNED: Apr. 16, 1967

23C. PHYSICIAN'S NAME (Type): E. Ellsworth Cook M.D.

23D. ADDRESS: 2431 Maryland Ave Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	4-18-1967	Western Cemetery	Baltimore, Co.	Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Lazarah Funeral Home 7401 Belair Road

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-2.63

BIRTH NO. 67 3834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3834

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HAZEL WRIGHT ESWORTHY

2. DATE AND HOUR OF DEATH: 4/15/67 4:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY OF MD. HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY: Carroll Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): SYKESVILLE 56-00

D. STREET ADDRESS (If rural, give location): RT #3 BOX 175

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 8/14/16

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSES AIDE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD. HOWARD Co.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EDWARD HATFIELD

14. MOTHER'S MAIDEN NAME: AMANDA WRIGHT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: 219-36-2387

17. INFORMANT: Mr. John A. Esworthy

ADDRESS: Same As #4

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

18. 422.1

(A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

METASTIC CA OF BREAST — 2 YEARS

19A. DATE OF OPERATION: 4/12/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: RECURRENT CA OF BREAST

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11/67 19 to 4/15/67 19, that (I) (we) last saw the deceased alive on 4/15/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fred N Sugar, MD.

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/11/67

23C. PHYSICIAN'S NAME (Type): FRED N. SUGAR M.D.

23D. ADDRESS: UNIVERSITY HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/1967

24C. NAME of CEMETERY or CREMATORY: Lakeview Memorial Gardens

24D. LOCATION (City, town, or county) (State): Carroll Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Foley M.D.

25C. FUNERAL DIRECTOR: C.M. Waltz

ADDRESS: Box 241 Sykesville, Md.

VS 150-REV. 1/1/65

0 3 8 4 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-156

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3835 Registered No. 67 3835

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Heavner, Alvin Elmer

2. DATE AND HOUR OF DEATH: APRIL 15, 1967 1:30PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218 — 27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — 24-04
D. STREET ADDRESS (If rural, give location): 1541 Light St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/4/31
9. AGE (In years last birthday): 36
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Cutter
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Branson Heavner
14. MOTHER'S MAIDEN NAME: Mary Goldizen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
If yes, give war or dates of service: 7/19/50-5/12/54
16. SOCIAL SECURITY NO.: 214-28-67-06
17. INFORMANT: Records
ADDRESS: Veterans Hospital, Balto., Md. 21218

MEDICAL CERTIFICATION

1B. 153.8

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronchial Pneumonia W/ Pulmonary Edema.
DUE TO
(B) Carcinoma Of The Colon
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 15, 1967 to April 15, 1967, that (I) (we) last saw the deceased alive on April 15, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sungill Shin M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: April 15, 1967
23C. PHYSICIAN'S NAME (Type): Sung Ill Shin M.D.
23D. ADDRESS: VETERANS HOSPITAL, BALTO., MD. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: Hillcrest Burial Pk.
24D. LOCATION (City, town, or county) (State): Cumberland Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: James Stein Inc.
ADDRESS: Cumb. Md.

VS 150-REV. 1/1/65

67 0 0 3 8 1 3

1
M-600

BIRTH NO. 67 3836

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3836

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REGINALD MOORE

2. DATE AND HOUR PRONOUNCED DEAD: 4-15-67 9:40 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
39 PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 3412 Woodbrook Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 10/22/03
9. AGE (In years last birthday): 63
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Retired) Male nurse
10B. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morris W. Moore
14. MOTHER'S MAIDEN NAME: Margaret Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: 220-07-4909
17. INFORMANT: Blanche M. Linsay ADDRESS: 3412 Woodbrook ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia following self - inflicted
XXXX
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) incision of neck
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3412 Woodbrook Avenue 13-04

21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 11 (Year) '67 (Hour) ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Cut throat and wrists

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4-16-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/21/67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Fackenthal
24C. FUNERAL DIRECTOR: W. J. Chatmanp
ADDRESS: 1701 McCulloh St. Balto. Md.

VS 151-REV. 1/1/65

N 874 367 0003 11

L-524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3837 Registered No. 67 3837

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Virginia M. Langellotto

2. DATE AND HOUR OF DEATH: April 12, 1967 10:15P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 So. Balto. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Anne Arundel Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Brooklyn Suburban 52-00
D. STREET ADDRESS (If rural, give location): 5414 Magee St.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 1, 1923
9. AGE (In years last birthday): 43 yrs.
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Charles Wissner
14. MOTHER'S MAIDEN NAME: Mildred Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. James A. Langellotto ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Vascular Accident (Hypertensive Crisis) — 420.0

DUE TO

(B) Arteriosclerotic Heart Disease, Obesity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity (not 391½)

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 17, 1962 to 4/13 1967, that (I) (we) last saw the deceased alive on April 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis Glass M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): Louis Glass M.D.
23D. ADDRESS: 320 Patapsco Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 17, 1967
24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Ritchie Hwy. A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT. APR 18 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: George J. Gonce ADDRESS: 4001 Ritchie Hwy. Baltol 2122

VS 150-REV. 1/1/65

1967 0 0 3 8 4 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3838 Registered No. 67 3838

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REGINA BLUMENSTEIN

2. DATE AND HOUR OF DEATH: 4/17/67 4.50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL, BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 15-11

D. STREET ADDRESS (If rural, give location): 3450 Dolfield Ave

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 9/6/90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herman

14. MOTHER'S MAIDEN NAME: Gertrude

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alford Bavine ADDRESS: 4402 Old Court Rd

MEDICAL CERTIFICATION

1B. 33/X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) multiple C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: 17 DAYS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A.S.C.V.D

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30 1967 to 4/17 1967, that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Eduardo Hidalgo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): EDUARDO HIDALGO M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/19/1967

24C. NAME of CEMETERY or CREMATORY: Anshe Emunah Cem Chevra

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Graham S. Levin & Son ADDRESS: Garrison, Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-516

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3839 Registered No. 67 3839

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REINBERG MARTHA

2. DATE AND HOUR OF DEATH: APRIL 18, 1967 | 2⁰⁰ A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 3812 GLEN AVE. #15

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 12/28/12
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: LOUIS
14. MOTHER'S MAIDEN NAME: HANNAH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: SOL REINBERG — ADDRESS: 3812 GLEN AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 1750

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) TERMINAL CARCINOMATOSIS

DUE TO (B) ADENO CARCINOMA OF OVARY.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 24, 1967 to APRIL 18, 1967, that (I) (we) last saw the deceased alive on APRIL 18, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/18/67.
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: Chevra Ahavas Chesed
24D. LOCATION (City, town, or county) (State): Randallstown Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Lackey M.D.
25C. FUNERAL DIRECTOR: Sylvan S. Levin & Son, Inc. — ADDRESS: Garrison, Md

VS 150-REV. 1/1/65

1967 0 0 0 3 8 1 7

P-236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3840 Registered No. 67 3840

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): POIST, WALTER

2. DATE AND HOUR OF DEATH: 4/16/67 6-15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 2911 Hammonds Ferry Rd.

46

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-11-92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: Paper hanger

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jerome Poist

14. MOTHER'S MAIDEN NAME: Ella F. Walker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-03-5035B

17. INFORMANT: Helen Frances. ADDRESS: 2911 Hammonds Ferry Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIO SCLEROTIC HYPERTEN

DUE TO

(B) SIVE CARDIO VASCULAR

DUE TO

(C) DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/16/67

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 19, 1967

24C. NAME of CEMETERY or CREMATORY: Meadowridge Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: G. Truman Schwab ADDRESS: 3512 Frederick Ave. Balto.

VS 150-REV. 1/1/65

3840

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3841 Registered No. 67 3841

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVERETT BULL

2. DATE AND HOUR OF DEATH: 4/17/67 8:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL 36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-07
D. STREET ADDRESS (If rural, give location): 3820 BEECH AVE

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7/25/10
9. AGE (In years last birthday): 56
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF Employed
10B. KIND OF BUSINESS OR INDUSTRY: GARAGE
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CLARENCE BULL
14. MOTHER'S MAIDEN NAME: NELLIE GAMBLE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): Yes-2nd W.W.
16. SOCIAL SECURITY NO.
17. INFORMANT: CHART
ADDRESS

MEDICAL CERTIFICATION

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ACUTE Myocardial Infarction 1 wk
DUE TO
(B) Congestive Heart failure 1 wk
DUE TO
(C) Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/9 1967 to 4/17 1967, that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R. Magno M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): RAYMUNDO S. MAGNO M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: Pine Grove
24D. LOCATION (City, town, or county) (State): Balto Co, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Paul E. Fogelman
25C. FUNERAL DIRECTOR: Austin E. Donovan
ADDRESS: 3818 Roland Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3842 Registered No. 67 3842

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rubenstein Ida

2. DATE AND HOUR OF DEATH: 4-17-67 10 05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Hebrew Home and Infirmary

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 4106 Woodhaven Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	White	widowed	March 15, 1879	88		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Russia	U.S.A.

13. FATHER'S NAME: ? Block

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Rose Rose 6802 Townbrook Dr. Apt. C — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 466 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: pulmonary embolism — 15 minutes

(B) DUE TO: Phlebothrombosis

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: ASCVD -

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-14 1960 to 4-17 1967, that (I) (we) last saw the deceased alive on 4-17-67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ruth Willner M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4.17.67

23C. PHYSICIAN'S NAME (Type): Ruth Willner M.D.

23D. ADDRESS: Levindale, Hebrew Home and Infirmary

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/18/67	Knesseth Israel Anshe Kolk Volyn Congr. Cem. Mt. Carmel	

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 19 1967	Robert E. Fankenna	Jack Lewis, Inc.	2100 Eutaw Place

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-630

BIRTH NO. 67 3843

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1749-30 67 3843

1. NAME OF DECEASED (Type or Print): MERRITT, JOHN R.

2. DATE AND HOUR OF DEATH: April 15, 1967 11:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MARYLAND HOSPITAL 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 16-07
D. STREET ADDRESS (If rural, give location): 3021 PRESTMAN ST

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWER
8. DATE OF BIRTH: 12-19-98
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer (ret)
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): N.C. Weldon
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: JOHN RICHARD MERRITT
14. MOTHER'S MAIDEN NAME: MOLLIE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Betty White, daughter, 3402 Rosedale Rd Baltimore

MEDICAL CERTIFICATION

18. 15 1X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Severe Myocardial Infarction — 1 to 2 days
DUE TO
(B) Bilateral Pneumonia — 3-5 days
DUE TO
(C) Adenocarcinoma of Stomach — unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Peritonitis, Arteriosclerotic Heart Disease

19A. DATE OF OPERATION: 4-6-67, 4-10-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CA STOMACH
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30/67 19 to 4/15/67 19, that (I) (we) last saw the deceased alive on 4/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert W McCurdy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-17-67
23C. PHYSICIAN'S NAME (Type): Robert McCurdy M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): A.A. Co. Md.

25A. DATE FILED BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Stalzman
25C. FUNERAL DIRECTOR: Morton & Dyett F.H.
ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-1001

BIRTH NO. 67 3844

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3844

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): SIPPIO, ADAM

2. DATE AND HOUR OF DEATH: 4-17-'67 | 9-30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 1813 W. Lafayette Ave.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5-11-1911
9. AGE (In years last birthday): 55 yrs
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Beth-Steel
11. BIRTHPLACE (State or foreign country): Florence, S.C.
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Albert Sippio
14. MOTHER'S MAIDEN NAME: Ida Sippio

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 237-22-3667
17. INFORMANT: Mrs. Ethel Sippio — ADDRESS: 1813 W. Lafayette

MEDICAL CERTIFICATION

18. 163 X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardio-respiratory arrest — ½ an hour
DUE TO marked pulmonary oedema
(B)
DUE TO Lung Carcinoma
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2-6-'67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma lungs (Rt)
20A. AUTOPSY? (Yes or No): No.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-7- 1967 to 4-17 1967, that (I) (we) last saw the deceased alive on 4-17- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joshi — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): Dr. ANILKUMAR M. JOSHI M.D.
23D. ADDRESS: Lutheran Hospital of Maryland, Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-22-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Fuhrman
25C. FUNERAL DIRECTOR: Morton Dyer Hall — ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

1967 0 0 3 8 5 2

R-4201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3845 Registered No. 67 3845

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTE S.T. RYALS

2. DATE AND HOUR OF DEATH: April 15, 1967 | 7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 507 N. Normandy Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-07

D. STREET ADDRESS (If rural, give location): 507 Normandy Avenue

5. SEX: M. 6. RACE: N. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5-21-96 9. AGE (In years last birthday): 70

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER

10B. KIND OF BUSINESS OR INDUSTRY: CHURCH

11. BIRTHPLACE (State or foreign country): HAWKINSVILLE, GA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES RYALS

14. MOTHER'S MAIDEN NAME: JOSEPHINE RYALS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Rebecca Ryals ADDRESS: 507 N. Normandy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 months

DUE TO

(B) Metastatic adenocarcinoma — unknown

DUE TO

(C) Adenocarcinoma of pancreas — unknown

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-23-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cholecystectomy

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 10-29 1964 to 4-10 1967, that (I) (~~we~~) last saw the deceased alive on 4-10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John T. Chissell M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-17-67

23C. PHYSICIAN'S NAME (Type): John T. Chissell M.D.

23D. ADDRESS: 1038 Edmondson Ave Baltimore Md 21223

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-21-67

24C. NAME of CEMETERY or CREMATORY: Union Baptist Ch. Cem.

24D. LOCATION (City, town, or county) (State): Cincinnati Ohio

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: MORTON & DYETT F.H. ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-45 D

67 3846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3846

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALLEN, MERCELL C.

2. DATE AND HOUR OF DEATH: 4/16/67 4-15 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 3501. W. Forest Park. Ave

46 15.38

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2-24-97

9. AGE (In years last birthday): 70

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia, Prospect

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Allen

14. MOTHER'S MAIDEN NAME: Sophia Blackface

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MINNIE, ADDRESS: 3501. W Forest Park

MEDICAL CERTIFICATION

18. 4 7 3 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRO VASCULAR ACCIDENT

DUE TO

(B) ARTERIOSCLEROTIC HYPERTENSIVE

DUE TO

(C) CARDIO VASCULAR DISEASE WITH CONGESTIVE FAILURE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/2/1967 to 4/16/1967, that (I) (we) last saw the deceased alive on 4/16/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: V. Biswanath Pillai M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 2/16/67

23C. PHYSICIAN'S NAME (Type): V. BISWANATH PILLAI M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-20-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Lackey M.D.

25C. FUNERAL DIRECTOR: Horton & Dyer F.H.

ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

R-520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3847 Registered No. 67 3847

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIE RHAMES

2. DATE AND HOUR PRONOUNCED DEAD: April 13, 1967 7:23 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital (DOA)

38 99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1332 N. Calhoun Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: 10-10-17
9. AGE (In years last birthday): 49
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEMPLOYED
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): SUMMERTON, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ADAM RHAMES
14. MOTHER'S MAIDEN NAME: MINNIE BETHUNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-56-7026
17. INFORMANT: Mrs. Minnie Riley
ADDRESS: 1705 Presstman

MEDICAL CERTIFICATION

18. 443 X

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.
EXAMINER'S NAME (Type) Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED April 14, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 4-19-67
23C. NAME of CEMETERY or CREMATORY: Mount Auburn Cem.
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: MORTON & DYETT F.H.
ADDRESS: 1701 I

VS 151-REV. 1/1/65

1 9 6 7 0 0 3 8 5 5

BIRTH NO. 67 3848

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3848

1. NAME OF DECEASED (Type or Print): MARY E. PURNELL

2. DATE AND HOUR OF DEATH: 4-16-67 | 6:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 1236 E. LAFAYETTE AVE

9-09

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 3-24-22

9. AGE (In years last birthday): 45

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: housewife

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN PURNELL

14. MOTHER'S MAIDEN NAME: JANE ELLIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary J. Purnell ADDRESS: 1236 E. Lafayette Avenue

MEDICAL CERTIFICATION

1B. 7531 I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardiac arrest

DUE TO

(B) CVS tuberous sclerosis (probable)

DUE TO

(C) Generalized tuberous sclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary embolus

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/7 1967 to 4/16 1967, that (I) (we) last saw the deceased alive on 4/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth L. Brigham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/16

23C. PHYSICIAN'S NAME (Type): Kenneth L. Brigham M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-19-67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Marshall W. Jones, Jr. ADDRESS: 1735 Harford Ave.

VS 150-REV. 1/1/65

1967 003856

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

PL 154

4 16 67

F-20b

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3849

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3849

1. NAME OF DECEASED (Type or Print): Mr Vernon F. Foos

2. DATE AND HOUR OF DEATH: April 13, 1967 8:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 99.6
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Forest Glen, Pasadena
D. STREET ADDRESS (If rural, give location): Box 313 RT #7 52-00

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Feb 14, 1897
9. AGE (In years last birthday): 70
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John E Foos
14. MOTHER'S MAIDEN NAME: Annie Benner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 705-03-9459
17. INFORMANT: Margaret M. Carski — ADDRESS: 2210 Southland Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — 36 hs
DUE TO
(B) ASCVD
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from April 12 1967 to April 13 1967, that ~~(I)~~ (we) last saw the deceased alive on April 13 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Wm Gregory Bruce M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: April 13, 1967
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-17-67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Fadyen
25C. FUNERAL DIRECTOR: Ellsworth Armacost — ADDRESS: 4600 Liberty Heights

VS 150-REV. 1/1/65

P-2-60

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3850

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3850

1. NAME OF DECEASED (Type or Print): FRANK PECORA

2. DATE AND HOUR OF DEATH: 4-14-67 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 28-41

D. STREET ADDRESS (If rural, give location): 4006 Eldorado Ave

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Sept 8, 1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph PECORA

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: John PECORA

ADDRESS: 501 Somerset Rd

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arterio Sclerotic Heart Disease — 5 yrs

DUE TO

(B) Chronic Prostatis — 3 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Generalized Arterio Sclerosis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 5 1965 to 4/14 1967. that (I) (~~we~~) last saw the deceased alive on April 10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Earl L. Chambers M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): Earl L. Chambers M.D.

23D. ADDRESS: 4108 Liberty Hts Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): Entombment

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Ralph E. Fulton

25C. FUNERAL DIRECTOR: Ellsworth Armacost

ADDRESS:

VS 150-REV. 1/1/65

F-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3851 Registered No. 67 3851

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sheppard A. Farren Sr. / Farren Sheppard

2. DATE AND HOUR OF DEATH: 4-17-67 | 2.30 AM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Charles General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-01
D. STREET ADDRESS (If rural, give location): 218 S. Washington

49

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 11-4-89
9. AGE (In years last birthday): 77 YRS. | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: R.R. Express Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward Farren
14. MOTHER'S MAIDEN NAME: Charlotte Mitchell
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: North Charles General
ADDRESS: Chart

MEDICAL CERTIFICATION

18. 584 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Paralitic ileus,
DUE TO
(B) post-cholecystectomy.
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-13-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Cholelythiasis
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-12 1967 to 4-17 1967, that (I) (we) last saw the deceased alive on 4-17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Stella M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-17-67
23C. PHYSICIAN'S NAME (Type): CARMELA STELLA M.D.
23D. ADDRESS: NORTH CHARLES HOSP

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-20-1967
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Roland E. Fogleman
25C. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: 1901-07 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620

BIRTH NO. 67 3852

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3852

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): M. Helena M. Powers — Helena Powers

2. DATE AND HOUR OF DEATH: APRIL 14 - 1967 | 12:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital 34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-03
D. STREET ADDRESS (If rural, give location): 2040 Hollins Street

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 1-8-95
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Button Hole Operator
11. BIRTHPLACE (State or foreign country): Maryland Baltimore
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Henry Moerken
14. MOTHER'S MAIDEN NAME: Monberger, Lena

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-09-3692
17. INFORMANT: Mrs. Ruth Vincent ADDRESS: 2040 Hollins Street

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 4221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-13
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abdominal aneurysm
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-3 1967 to 4-14 1967, that (I) (we) last saw the deceased alive on 4-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jorge B. Joaquino M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-14-67
23C. PHYSICIAN'S NAME (Type): JORGE B. JOAQUINO M.D.
23D. ADDRESS: Bon Secours Hospital Baltimore, MD. 21223

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 4-17-1967
24C. NAME of CEMETERY or CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Fogleman
25C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 1901-07 Eastern Ave.

VS 150-REV. 1/1/65

3860

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N-265

BIRTH NO. 67 3853

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3853

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOUIS C. NYGREN

2. DATE AND HOUR PRONOUNCED DEAD: April 18, 1967 3:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2 N. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05

D. STREET ADDRESS (If rural, give location): 2 N. Broadway

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Feb. 25, 1902

9. AGE (In years last birthday): 65

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Crain Operator

11. BIRTHPLACE (State or foreign country): Westminster, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Dohney Nygren

14. MOTHER'S MAIDEN NAME: Louise Citic

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-01-4941

17. INFORMANT: Mrs. Margaret Nygren ADDRESS: 2 N. Broadway

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-21-1967

23C. NAME of CEMETERY or CREMATORY: Bel Air Memorial Gardens

23D. LOCATION (City, town, or county) (State): Bel Air, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 1901-07 Eastern Ave.

VS 151-REV. 1/1/65

1 6 7 0 0 3 8 6 1

R 32-21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3854 Registered No. 67 3854

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PATAJCZAK, KATHERINE M.

2. DATE AND HOUR OF DEATH: 4-18-67 | 11⁴⁵ A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: Maryland
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore F-04
D. STREET ADDRESS (If rural, give location): 2637 Hudson Street

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 1/1/00
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Packing House
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Stanley Waniewski (WANIECKI)
14. MOTHER'S MAIDEN NAME: Veronica Simski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-10-5307
17. INFORMANT: Mrs. Eleanor Ament ADDRESS: 820 South Rose Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest
DUE TO
(B) poss M.I.
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/18 1967 to 4/18 1967, 11:20 am 11:45 am, that (I) (we) last saw the deceased alive on 4/18 1967 and that In(my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P Rosen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): P. Rosen M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/21/67
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705 South Ann Street
George A. Weber

VS 150-REV. 1/1/65

1967 00 3862

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

34-49-59 GG 10-343 67 3855

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3855

1. NAME OF DECEASED (Type or Print): (DENA) Chloe Odewalt

2. DATE AND HOUR OF DEATH: 4-15-67 1045 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue B altimore 21224, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 14-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1802 Eutaw Place 21217

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 2-7-91
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Montgomery
14. MOTHER'S MAIDEN NAME: Jennie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue #21224
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Reticulum cell Sarcoma — INTERVAL BETWEEN ONSET AND DEATH: Yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-24- 19 67 to 4-15- 19 67, that (I) (we) last saw the deceased alive on 4-15- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bruce G Whipple M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-15-67
23C. PHYSICIAN'S NAME (Type): Dr. Bruce G. Whipple M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Avenue #21224

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: April 19-67
24C. NAME of CEMETERY or CREMATORY: LOUDEN PARK
24D. LOCATION (City, town, or county) (State): 3801 Fred Ave Ba Md

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Ralph E. Farley M.D.
25C. FUNERAL DIRECTOR: T. FISHER - 1930 EASTERN AVE BA (31)
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3856 Registered No. 67 3856

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elmer Lewis

2. DATE AND HOUR OF DEATH: 4-16-67 1:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 15-06
D. STREET ADDRESS (If rural, give location): 1801 Ashburton Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Apr.29,1931
9. AGE (In years last birthday): 35 yrs.
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Lewis
14. MOTHER'S MAIDEN NAME: Georgia Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-26-0213
17. INFORMANT: Elizabeth Taylor - sis. ADDRESS: 1305 W. Lanvale St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4-20.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

Cerebral vascular accident

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 23, 1967 to April 16, 1967, that (I) (we) last saw the deceased alive on April 16, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. Laredo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-17-67
23C. PHYSICIAN'S NAME (Type): C. LAREDO M.D.
23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Apr.19/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Ceder Hill Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Ralph E. Talbert
25C. FUNERAL DIRECTOR: Williams Funeral Home
ADDRESS: 3197 Schroeder St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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Y-616

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3857 Registered No. 67 3857

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PAUL YARBOROUGH

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1062 Vine Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 1062 Vine Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married Sep.
8. DATE OF BIRTH: July 30, 1927
9. AGE (In years last birthday): 39
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick layer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Zeberlon N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Yarborough
14. MOTHER'S MAIDEN NAME: Addie Bunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): yes
16. SOCIAL SECURITY NO.: AF52 290 268
17. INFORMANT: John Yarborough ADDRESS: 404 Jumpers Hole R

MEDICAL CERTIFICATION

1B. 490 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Apr. 21, 1967
23C. NAME of CEMETERY or CREMATORY: Balto. National
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE RECEIVED HEALTH DEPT. APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Williams Funeral Home ADDRESS: 3199 Belvedere Ave

VS 151-REV. 1/1/65

1967 0003865

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B. 632

BIRTH NO. 67 3858

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3858

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MATTHEW BRIDGERS

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 | 4:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39/99 Provident Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03
D. STREET ADDRESS (If rural, give location): 1504 Ellwood Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 12, 1941
9. AGE (In years last birthday): 26 25
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Clayton N. Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Liberty Bridgers
14. MOTHER'S MAIDEN NAME: Dessie Vinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service:
16. SOCIAL SECURITY NO.
17. INFORMANT: Deborah Bridgers
ADDRESS: 411 Marion St N.E. Aiken S.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E976 X

(A) Contact gunshot wound of chest

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): house
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2019 Druidhill Avenue 14-03

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4-17-67 ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Apparently shot self in chest

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: April 21/67
23C. NAME of CEMETERY or CREMATORY: Bolt Natl. Cem.
23D. LOCATION (City, town, or county) (State): 5501 Frederick Av. Baltimore

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Grant T. Eleckson
ADDRESS: 1129 N. Carlton St

VS 151-REV. 1/1/65

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3859 Registered No. 67 3859

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edward J. Srebrowski

2. DATE AND HOUR OF DEATH: 4/17/67 7:45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 103
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2416 Fait Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 5/16/15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Dept. Sanitation
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Theodore Srebrowski
14. MOTHER'S MAIDEN NAME: Martha Adams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 215-12-5675
17. INFORMANT: Evelyn Srebrowski
ADDRESS: Same

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PULMONARY EDEMA
DUE TO
(B) PORTAL CIRRHOSIS
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 13 1967 to April 17 1967, that (I) (we) last saw the deceased alive on April 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): W. MICHAEL GOULD M.D.
23D. ADDRESS: MARYLAND GENERAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: HOLY REDEEMER CEM
24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Ralph E. Tarkey M.D.
25C. FUNERAL DIRECTOR: JOHN M WEBER & SONS INC.
ADDRESS: 401 S. CHESTER ST.

VS 150-REV. 1/1/65

1967 0 0 3 8 5 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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W.200

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3860 Registered No. 67 3860

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT WISE

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 | 7:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1834 Druidhill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 1834 Druidhill Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/2/18
9. AGE (In years last birthday): 48
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert Wise,
14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W W 2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Geraldine Wise
ADDRESS: 1834 Druid Hill Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

1B. 424-3X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/21/67
23C. NAME of CEMETERY or CREMATORY: National Cemetry
23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/65

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R-262

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH No. 67 3861 Registered No. 67 3861

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): OAKLEY (RODGERS) ROGERS

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 8:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 537 South Paca Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 537 South Paca Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8/20/94
9. AGE (In years lost birthday): 73 72
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unk.
14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-01-0032
17. INFORMANT: Naomi Rogers ADDRESS: 537 S. Paca St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4-20-0

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/21/67
23C. NAME of CEMETERY or CREMATORY: Baltimore National
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

1967 0003869

B-660

BIRTH NO. 67 3852

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3852

1. NAME OF DECEASED (Type or Print): Robert Berry

2. DATE AND HOUR OF DEATH: 4/18/67 8:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 944 North Gay Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	5/6/85	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salem New Jersey

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Berry

14. MOTHER'S MAIDEN NAME: Emma Thomas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Viola Berry

ADDRESS: 1510 E. Madison St

MEDICAL CERTIFICATION

I

1B. 181.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) CA bladder

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Patient was DOA on arrival at JHH to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Peter Z Rosen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): Peter Rosen M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: April 21/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): Salem New Jersey

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Milton E. Elkins

ADDRESS: 1129 N. Carlton St

VS 150-REV. 1/1/65

967 0 3852

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-363

BIRTH NO. 67 3863

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3863

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Lillian Lucille Barker Street

2. DATE AND HOUR OF DEATH: April 18, 1967 4:0 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): OO 3342 Dolfield Av.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3342 Dolfield Ave.

5. SEX: Female
6. RACE: Colored
7. MARITAL STATUS (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)): Married
8. DATE OF BIRTH: April 5, 1917
9. AGE (In years last birthday): 50
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mehurin Virginia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Eddie Barker
14. MOTHER'S MAIDEN NAME: Lelia Barker

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Claudell K. Street
ADDRESS: 3342 Dolfield Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: "

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (~~this hospital~~) attended the deceased from January 26 1967 to April 16 1967, that (I) (~~we~~) last saw the deceased alive on April 16 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Royston B Scott M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: April 18 67
23C. PHYSICIAN'S NAME (Type): ROYSTON B SCOTT M.D.
23D. ADDRESS: 1801 W BALTIMORE ST, Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 22/67
24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Arbutus, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Parker, M.D.
25C. FUNERAL DIRECTOR: Fred T. Erickson
ADDRESS: 1129 N. Carolina St.

VS 150-REV. 1/1/65

9 6 7 0 0 3 8 7 1

F-630

BIRTH NO. 67 3864

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3864

1. NAME OF DECEASED (Type or Print): OSCAR O. FORD

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 11:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1803 N. Dallas Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1803 N. Dallas Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	Negro	Married	12-24-1907	59	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Steel Co.	Brooklyn, N.Y.	U.S.A.

13. FATHER'S NAME: Zacharias Ford

14. MOTHER'S MAIDEN NAME: Augustus Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-03-6267

17. INFORMANT: Mrs Hazel Ford ADDRESS: 1803 N. Dallas St.

MEDICAL CERTIFICATION

18. 422.1 + 164X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma of Mediastinum (type unspecified)

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-21-67	Mt. Calvary Cemetery	Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 19 1967	Robert E. Lankey M.D.	Randolph J. Collick	2431 E. Oliver St.

VS 151-REV. 1/1/65

1967000 3872

W-256

67 3865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 3865

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE JOHN WAGNER

2. DATE AND HOUR OF DEATH: 4/18/67 | 6:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF ~~HOSPITAL OR~~ INSTITUTION: Maryland General Hosp

(If not in hospital or institution, give street address or location): 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 6-02

D. STREET ADDRESS (If rural, give location): 437 N. Florida St.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 5/4/92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: RAILWAY EXPRESS

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Wagner

14. MOTHER'S MAIDEN NAME: Elizabeth Schaffer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: niece | ADDRESS: Elz. Dandy

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) acute anterioseptal MI — days

DUE TO

(B) ASCVD — years

DUE TO

(C) CVA — terminal

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Severe dehydration

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/16 1967 to 4/16 1967, that (I) (we) last saw the deceased alive on 4/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 827 Linden Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-22-67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE RECD BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: John A. Miller | ADDRESS: Montford & Jefferson

VS 150-REV. 1/1/65

1967 0 0 3 8 6 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-460 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3866 Registered No. 67 3866

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMMA ELIZABETH CATHERINE SCHULER

2. DATE AND HOUR OF DEATH: 4-18-67 9 or A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 6-03
D. STREET ADDRESS (If rural, give location): 404 N. BRADFORD ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	2-7-1901	66		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	HOME	MARYLAND	U.S.A.

13. FATHER'S NAME: CHRISTOPHER FEWSTER

14. MOTHER'S MAIDEN NAME: MARGARET J. QUICK.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	—	Mr. Robert J. Schuler	404 N. Bradford St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — sudden

DUE TO

(B) Arteriosclerotic Hypertensive disease — 6 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 5 1967 to April 18 1967, that (I) (~~We~~) last saw the deceased alive on April 11 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death. D.O.A. at Church Home & Hospital

23A. SIGNATURE: George D. Lippy M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): George D. Lippy M.D.

23D. ADDRESS: 426 S. Patterson Pk Ave Baltimore Md 21223

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4-21-67	BALTO. NATIONAL CEM.	BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 19 1967	[illegible]	Hartley Miller	2334 Jefferson St.

VS 150-REV. 1/1/65

3 7 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-266

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO. 67 3867

Registered No. 67 3867

A

1. NAME OF DECEASED (Type or Print): MICHELE FISHER

2. DATE AND HOUR OF DEATH: 4-18-1967 12,45 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: PENNSYLVANIA

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): YORK V-35

D. STREET ADDRESS (If rural, give location): 1820 HAYWARD RD.

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): CHILD.

8. DATE OF BIRTH: 2-6-1958

9. AGE (In years last birthday): 7

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Pennaylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROY FISHER

14. MOTHER'S MAIDEN NAME: CHAROLETTE SOEFFLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: John Hopkins Hospital Records, ADDRESS: Same as# 3

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 7354.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Hypoxia - without exacerbation

DUE TO

(B) Pulmonary Embolism and Pulmonary A-V shunting — 1 month

DUE TO

(C) Etiology of Fallot — 8 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute Viral Influenza — 6 hours

19A. DATE OF OPERATION: 3/21/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Etiology of Fallot

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 15 1967 to April 18 1967, that (I) (we) last saw the deceased alive on April 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William B. Ames M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 18 April 67

23C. PHYSICIAN'S NAME (Type): DR. WILLIAM IMES M.D.

23D. ADDRESS: Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: Apr. 20, 67

24C. NAME of CEMETERY or CREMATORY: Greenmount Cemetery

24D. LOCATION (City, town, or county) (State): York, Pennsylvania

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Fabian

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, ADDRESS: 1050 York Road Towson, Md. 21204

VS 150-REV. 1/1/65

0 3 8 7 5

B-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67 3868

BIRTH NO. 67 3868
M.E. CASE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): BROWN, ELIZABETH

2. DATE AND HOUR OF DEATH: April 12, 1967 — 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Belton Hill Nursing Center

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 5010 Harford Road

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	White	Single	7-15-86	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cashier	Shipping Dept	Balto, Md	U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Mrs. Mary Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 211-05-9803A

17. INFORMANT: Mrs Zeiler — ADDRESS: Christopher Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS
DUE TO
(B) ARTERIO SCLEROSIS
DUE TO
(C) DIABETES MELLITUS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/27/67 19 to 4/12/67 19, that (I) (we) last saw the deceased alive on 4/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/12/67

23C. PHYSICIAN'S NAME (Type): HOWARD DEMARLINE M.D.

23D. ADDRESS: 930 WHITELOCK ST

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/15/67	Parkwood	Balto Md

25A. DATE RECEIVED BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 19 1967	Delgado E. Tabey, M.D.	J. A. Hegemann	6667 Hayward

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-630

67 3869

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3869

1. NAME OF DECEASED (Type or Print): MINNIE PRATT

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 6:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: Colchester

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 3916 ~~Cold Chester~~ Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-41

D. STREET ADDRESS (If rural, give location): 3916 ~~Cold Chester~~ Colchester Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 11/10/80

9. AGE (In years last birthday): ~~88~~ 87

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Washington Asbury

14. MOTHER'S MAIDEN NAME: Rebecca Daughtry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 4221.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/21/67

23C. NAME of CEMETERY or CREMATORY: Ridgedale Cemetery

23D. LOCATION (City, town, or county) (State): Chatham Hill, Rich Valley, Va.

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Hhoward H. Hubbard

ADDRESS: 4107 Wilkens Ave. Balto., Md. 21229

VS 151-REV. 1/1/65

1 9 6 7 0 0 3 8 7 7

G-152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3870 Registered No. 67 3870

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GIBBONS, GLADYS R.

2. DATE AND HOUR OF DEATH: 04 16 67 5:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 20-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ZONE 21223
D. STREET ADDRESS (If rural, give location): 2124 EAGLE STREET

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 06 11 02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CHARLES FITZHUGH
14. MOTHER'S MAIDEN NAME: ETHEL BLAIN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: ST. AGNES RECORDS — ADDRESS: CATON & WILKENS AVES BALTO. 29

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

18. 491 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral bronchopneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A.S.C.V.D.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from APRIL 7 1967 to APRIL 16 1967, that (X) (we) last saw the deceased alive on APRIL 16 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (We) (did) (X) (X) (at) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 04-17-67
23C. PHYSICIAN'S NAME (Type): E. H. WEISS
23D. ADDRESS: BALTO., MD. 21229 M.O. ST. AGNES HOSPITAL-CATON & WILKENS AVES.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: Robert E. Lankey
25C. FUNERAL DIRECTOR: Hubbard Funeral Home ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65 967 0 0 3870

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3871 Registered No. 67 3871

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JACK MIGLIORETTI

2. DATE AND HOUR OF DEATH: 4/13/67 3:45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MARYLAND B. COUNTY: BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township): 27-02 D. STREET ADDRESS (If rural, give location): 4314 Walther Ave. - 21214

5. SEX: MALE 6. RACE: CAUC. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: 10-28-97 9. AGE (In years last birthday): 69 If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PUBLIC CONTACT 10B. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED TRAVEL AGENCY 11. BIRTHPLACE (State or foreign country): ITALY (Masserano) 12. CITIZEN OF WHAT COUNTRY? US-NATURALIZED

13. FATHER'S NAME: CHARLES MIGLIORETTI 14. MOTHER'S MAIDEN NAME: SECONDA MARUCCHI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 216-05-9419 17. INFORMANT: GLORIA KUEHEER ADDRESS: 1531 PICKETT RD., LUTHERVILLE, MD.

MEDICAL CERTIFICATION

1B. 443X I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — (A) Cerebral Hemorrhage DUE TO; (B) Hypertensive Cardiovascular disease DUE TO; (C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/12 1967 to 4/13 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 4/13/67

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS: 827 Linden ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4-17-67 24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967 25B. NAME OF REGISTRAR: [signature] 25C. FUNERAL DIRECTOR: John C. Miller Inc-6415 Belair Road-21206 ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-415-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3872 Registered No. 67 3872

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ethel C. Schleupner

2. DATE AND HOUR OF DEATH: April 14, 1967 | 10:15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 Monumental Life Insurance Co. Charles & Chase Streets

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 2047 Woodbourne Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: April 30, 1902
9. AGE (In years last birthday): 64
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Monumental Life
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry A. Parr
14. MOTHER'S MAIDEN NAME: Anna Freedy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Audrey Amoss
ADDRESS: 2047 Woodbourne Ave. 21214

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO

(B) Arteriosclerotic C V D. — 3 YRS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 26, 1963 to April 14, 1967, that (I) (~~we~~) last saw the deceased alive on March 13 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-15-67
23C. PHYSICIAN'S NAME (Type): S.J. VENABLE, JR M.D.
23D. ADDRESS: 7215 York Rd, Baltimore MD

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 18, 1967
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: John C. Miller Inc-6415 Belair Road-21206
ADDRESS

VS 150-REV. 1/1/65

3880

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-651

BIRTH NO. 67 3873

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3873

1. NAME OF DECEASED (Type or Print): TURNER, JR. LEO J.

2. DATE AND HOUR OF DEATH: 4-16-67 5:30P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE Balto. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE 21228

D. STREET ADDRESS (If rural, give location): WILTON FARM DAIRY 53-00

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 10 25 44

9. AGE (In years last birthday): 22

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HANDYMAN

10B. KIND OF BUSINESS OR INDUSTRY: WASHINGTON ALUM. CO.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LEO TURNER

14. MOTHER'S MAIDEN NAME: MARGUERITE RILEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212462038

17. INFORMANT: ST. AGNES RECORDS - CATON & WILKENS AVES ADDRESS

MEDICAL CERTIFICATION

18. 592X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Glomerulonephritis DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 22 1967 to APRIL 16 1967, that (I) (we) last saw the deceased alive on APRIL 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Korbly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): S. KORBLY M.D.

23D. ADDRESS: St Agnes Hospital Caton & Wilkens

24A. BURIAL CREMATION, REMOVAL (Specify): BIRIAL

24B. DATE: 4/19/67

24C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEMETERY

24D. LOCATION (City, town, or county) (State): BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Stanley M.D.

25C. FUNERAL DIRECTOR: HOWARD H. HUBBARD ADDRESS: 4107 WILKENS AVE. 21229

VS 150-REV. 1/1/65

1967 0 0 3 8 8 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-554

BIRTH NO. 67 3874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3874

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ida A. Sonnenleiter

2. DATE AND HOUR OF DEATH: April 14, 1967 | 8 00 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1917 Breitwert Ave.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-43

D. STREET ADDRESS (If rural, give location): 1917 Breitwert Ave. 21230

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Jan. 12, 1895

9. AGE (In years last birthday): 72

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John P. Niemeyer

14. MOTHER'S MAIDEN NAME: Tena

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 217-20-5028 B

17. INFORMANT: John G. Sonnenleiter ADDRESS: 1917 Breitwert Ave. 21230

MEDICAL CERTIFICATION

1B. 600.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Uremia secondary to — 6 mos.

DUE TO

(B) Chronic Pyelonephritis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2/10/67 19 to 4/14/67 19, that (I) (~~we~~) last saw the deceased alive on 4/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C. Arthur Rossberg M.D. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): Dr. Charles Rossberg M.D.

23D. ADDRESS: 2436 Washington Blvd. Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/18/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Stanley M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

1967 0 0 3 8 8 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-240

BIRTH NO. 67 3875

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3875

1. NAME OF DECEASED (Type or Print): Russell, Dorothy Nell

2. DATE AND HOUR OF DEATH: 4/15/67 | 6:25 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Texas

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Menard

V-40

D. STREET ADDRESS (If rural, give location):

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 1/31/11

9. AGE (In years last birthday): 56

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreign Service

10B. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't State Dept

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Max Russell

14. MOTHER'S MAIDEN NAME: Alice Wilkinson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: The Deceased

ADDRESS: Menard, Texas

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hepatic coma — 6 days

DUE TO

(B) Metastatic Carcinoma of Breast — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4/3/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hepatomegaly + pain

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: — While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from March 24 19 67 to April 15 19 67, that (I) (we) last saw the deceased alive on April 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. C. Colston M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): ANNE C COLSTON M.D.

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: Resthaven ~~XXXXXX~~ Cemetery

24D. LOCATION (City, town, or county) (State): Menard Texas

25A. DATE REC'D BY HEALTH DEPT.: APR 19 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard Funeral Home

ADDRESS: 4407 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3876 Registered No. 67 3876

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GORDON POLAND

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 12:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 34/99 Bon Secours Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-03
D. STREET ADDRESS (If rural, give location): 1932 Hollins Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: FEB. 20. 1925
9. AGE (In years last birthday): 42
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALEMAN
10B. KIND OF BUSINESS OR INDUSTRY: USED CAR
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERBERT POLAND
14. MOTHER'S MAIDEN NAME: LAURA ACORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 216-18-4720
17. INFORMANT: CLARA M. POLAND ADDRESS: 5900 FRANKFORD AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 4-20-1967
23C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEMETERY
23D. LOCATION (City, town, or county) (State): BALTIMORE - MD.

24A. DATE REC'D BY HEALTH DEPT.: APR 19 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: WALTERS FUNERAL HOME
ADDRESS: PRATT & STRICKER STS.

VS 151-REV. 1/1/65

1967 0 0 0 3 8 8 4

R-180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3877 Registered No. 67 3877

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOSEPH A. RABE

2. DATE AND HOUR OF DEATH April 17, 1967. 6:40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3308 Northway Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-05

D. STREET ADDRESS (If rural, give location) 3308 Northway Drive

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married

8. DATE OF BIRTH March 22, 1915.

9. AGE (In years last birthday) 52

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Rabe

14. MOTHER'S MAIDEN NAME Pauline Hoffmann Brader

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-10-8972

17. INFORMANT Mrs. Mary R. Babe ADDRESS (Same)

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Occlusion — Few Minutes

DUE TO

(B) Coronary Heart Disease — Several Years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1957 19 to April 1 19 67, that (I) (~~we~~) last saw the deceased alive on April 15 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE Loy M. Zimmerman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED Apr. 18, 67

23C. PHYSICIAN'S NAME (Type) Loy M. ZIMMERMAN M.D.

23D. ADDRESS 3202 Harford Rd. Baltimore, Md

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 4/21/67

24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. APR 19 1967

25B. NAME OF REGISTRAR Robert E. Falkenna

25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. ADDRESS Balto. Md. 21214

VS 150-REV. 1/1/65

1967 0 0 3 8 8 5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-612

BIRTH NO. 67 3878

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3878

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): KRIVOSH, REV. MICHAEL

2. DATE AND HOUR OF DEATH: 4. 18. 67 | 1 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSP.

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 5503 ELSRODE AVE. (14)

27-06

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	MARRIED	7.25.91	75				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINISTER (Retired)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CZECHoslovakia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 218-40-2209

17. INFORMANT: Mrs. Mary Krivosh CHURCH HOME & HOSP. ADDRESS (Same)

MEDICAL CERTIFICATION

1B. 204.4 I 5811

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bleeding G. I. Tract → one day

DUE TO

(B) Leukoemia (C.L.L.) → one year

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Laennec Cirrhosis & Portal Hypertension & Ascites

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4. 7. 1967 to 4. 18 1967, that (I) (we) last saw the deceased alive on 4. 18. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Francisco Baltazar Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR JR

23D. ADDRESS: CHURCH HOME & HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/21/67.	Parkwood Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 19 1967	Robert E. Jones	Leonard J. Ruck, Inc.	Balto. Md. 21214

VS 150-REV. 1/1/65

67 0 0 0 3 8 8 6

E-263

BIRTH NO. 67 3879

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3879

1. NAME OF DECEASED (Type or Print): CHARLES WILLIAM ECKERT

2. DATE AND HOUR OF DEATH: APRIL 18 1967 | 10 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
216 S. SMALLWOOD ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-05
D. STREET ADDRESS (If rural, give location): 216 S. SMALLWOOD ST.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	SINGLE	JUNE 15 1889	77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	SEAFOOD	MARYLAND	U.S.A.

13. FATHER'S NAME: JULIUS ECKERT

14. MOTHER'S MAIDEN NAME: EMMA RUCIK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	NONE	220-44-7271	VERNON ECKERT	BOX 119 M, ROUTE 11 PASADENA, MD.

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis — Sudden
DUE TO
(B) Cardio-vascular Disease — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 18 1967 to April 18 67 19, that (I) (we) last saw the deceased alive on April 18 67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Henry Glassman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 19 67

23C. PHYSICIAN'S NAME (Type): HARRY GLASSMAN M.D.

23D. ADDRESS: 712 W. Fayette St.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4-21-67	LOUDON PARK	BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 20 1967	Robert E. Farley M.D.	GEO. L. SCHWAB FUNERAL HOME	Francis H. Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

1967 0 0 3 8 8 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-310

BIRTH NO. 67 3880

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3880

1. NAME OF DECEASED (Type or Print): HELENA VIRGINIA GUYTHER

2. DATE AND HOUR OF DEATH: APRIL 16, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MRRCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY: ST. MARYS — St Marys
C. CITY OR TOWN (If outside city limits, write RURAL and give township): MECHANICSVILLE — 68-00
D. STREET ADDRESS (If rural, give location):

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 9/15/1885
9. AGE (In years last birthday): 81
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POST MISTRESS RET:
10B. KIND OF BUSINESS OR INDUSTRY: US POST OFFICE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH F. ROBRECHT
14. MOTHER'S MAIDEN NAME: ANNA TWILLEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214 52 6136
17. INFORMANT: MR. ROY GUYTHER — ADDRESS: MECHANICSVILLE, MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 + 153.8

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Recurrent Pulmonary Embolus

DUE TO

(B) Previous Pulmonary Embolus

DUE TO

(C) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of Colon, possibly + Metastases

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 4-7 1967 to 4-16 1967, that (I) (~~we~~) last saw the deceased alive on 4-7 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Michael A. Ellis M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-16-67
23C. PHYSICIAN'S NAME (Type): Michael A. Ellis M.D.
23D. ADDRESS: Mercy Hospital Balto Md

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: TRINITY MEMORIAL GARDENS
24B. LOCATION (City, town, or county) (State): WALDORF, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Joseph M. Welch — ADDRESS: Leonardtown Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

O - 646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3881 Registered No. 67 3881

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret O'Reilly

2. DATE AND HOUR OF DEATH: April 18, 1967 7:50 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Psychiatric Institute, 6420 Reisterstown Road, Baltimore, Maryland 21215

21

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 28-40
D. STREET ADDRESS (If rural, give location): 6420 Reisterstown Rd

5. SEX	6. RACE	7. MARITAL STATUS (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Single	12-1-98	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Religious - Sister	Religious	Cambridge, Massachusetts	U. S.

13. FATHER'S NAME: James O'Reilly

14. MOTHER'S MAIDEN NAME: Catherine Cochran

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: -?-

17. INFORMANT: (Seton Records) ADDRESS:

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Chronic myocardial degeneration — 5 yrs.

DUE TO

(B) General arteriosclerosis — over 5 yrs.

DUE TO

(C) Cardio-vascular Hypertension — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Schizophrenic reaction, chronic undifferentiated — over 40 yrs.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 21 19 61 to April 18, 19 67, that (I) (we) last saw the deceased alive on April 18, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter O. Jahrreiss M.D. Attending Phys. ☐ for Med. Director ☑ Staff Phys. ☐

23B. DATE SIGNED: April 18, 1967

23C. PHYSICIAN'S NAME (Type): Walter O. Jahrreiss M.D.

23D. ADDRESS: 6420 Reisterstown Rd., Baltimore, Md.

24A. BURIAL CREMATION REMOVAL (Specify): burial

24B. DATE: Apr 19-67

24C. NAME of CEMETERY or CREMATORY: Seton

24D. LOCATION (City, town, or county) (State): Balto Md 21215

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Jackson

25C. FUNERAL DIRECTOR: Steuart & Monroe Co.

ADDRESS: Balto 21201

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3882 Registered No. 67 3882

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CURRY, OWEN J.

2. DATE AND HOUR OF DEATH: 4/17/67 340 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY of MARYLAND UNIVERSITY HOSPITAL 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt 16-07
D. STREET ADDRESS (If rural, give location): 3003 LYTTLETON RD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Sep
8. DATE OF BIRTH: 7/17/94
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman (ret)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MASS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George H. Curry
14. MOTHER'S MAIDEN NAME: Mary O'HARA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Hospital chart
ADDRESS:

MEDICAL CERTIFICATION

1B. 45 1/2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) abdominal aneurysmectomy — 7 days

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Idiopathic thrombocytopenic purpura, respiratory failure-chronic

19A. DATE OF OPERATION: 4/10/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ITP and aneurysm
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/4/67 19 to 4/17/67 19, that (I) (we) last saw the deceased alive on 4/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nicholas C. Bosch M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/17/67
23C. PHYSICIAN'S NAME (Type): NICHOLAS C. BOSCH M.D.
23D. ADDRESS: University of Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Mem. Park
24D. LOCATION (City, town, or county) (State): Howard Co. Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Thomas J. Kenny Inc
ADDRESS: Balto Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-63D

BIRTH NO. 67 3883

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3883

1. NAME OF DECEASED (Type or Print): Dr. DANIEL I. SCHWARTZ

2. DATE AND HOUR OF DEATH: 4-15-67 | 11 55 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL INC

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 11. SLADE AVE., APT. 714

42

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10/4/10

9. AGE (In years last birthday): 56

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHYSICIAN

10B. KIND OF BUSINESS OR INDUSTRY: GENERAL

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: MORRIS SCHWARTZ

14. MOTHER'S MAIDEN NAME: MARY SEIDMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): W.W. 11 AIRFORCE

16. SOCIAL SECURITY NO.: 214-46-9023

17. INFORMANT: MRS. LENORE SCHWARTZ, 11 SLADE AVENUE, APT 714

ADDRESS

MEDICAL CERTIFICATION

163X

I

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) CARCINOMA OF LUNG

DUE TO

(B) & METASTISES

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2/22/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: MASS IN LUNG

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/12 1967 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allan Lano

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/15/67

23C. PHYSICIAN'S NAME (Type): ALLAN LANO

M.D.

23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/17/67

24C. NAME of CEMETERY or CREMATORY: HAR SINAI

24D. LOCATION (City, town, or county) (State): GARRISON, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Fallon

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., 6010 REIST., RD.

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6

G-435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3884 Registered No. 67 3884

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLA R. GOLDMAN

2. DATE AND HOUR OF DEATH: 4/14/67 10:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTY: Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 6812 ALTER [redacted] AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	WID	9/10/84	82		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	[redacted] RUSSIA	U.S.A.

13. FATHER'S NAME: BENJAMIN PLOTNICK

14. MOTHER'S MAIDEN NAME: ETTA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-52-0550

17. INFORMANT: CHART HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) MYOCARDIAL INFARCTION — 5 DA.
DUE TO
(B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 19 67 to 4/14 19 67, that (I) (we) last saw the deceased alive on 4/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sheldon Frank M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): SHELDON FRANK M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4/16/67	ANSHE EMUNAH - (AITZ CHAIM)	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. ~~FUNERAL~~ DIRECTOR	ADDRESS
APR 20 1967	Robert E. Fahey M.D.	SOL LEVINSON & BROS. INC.	6010 REISTERSTOWN

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H 1250

BIRTH NO. 67 3885

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3885

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BELLE HEYISON

2. DATE AND HOUR OF DEATH: 4/14/67 1:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 3525 Park Heights Avenue

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 75 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Latvia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Abraham Berlin
14. MOTHER'S MAIDEN NAME: Ida ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Mrs. Dena Levine — ADDRESS: 7025 Surrey Drive #15

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Myocardial Infarction — 2 weeks

(B) DUE TO: Hypertensive Arteriosclerotic Cardiovascular Disease

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30 1967 to 4/14 1967, that (I) (we) last saw the deceased alive on 4/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Abe Levy M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/14/67
23C. PHYSICIAN'S NAME (Type): ABE LEVY M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/16/67
24C. NAME of CEMETERY or CREMATORY: Mogan Abraham
24D. LOCATION (City, town, or county) (State): Rosedale, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc. — ADDRESS: 6010 Reist. Rd.

VS 150-REV. 1/1/65

R-355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3886 Registered No. 67 3886

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Herman Rottman

2. DATE AND HOUR OF DEATH: April 13, 1967 7 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural give location): 6957 Brookmill Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: March 7, 1895

9. AGE (In years last birthday): 72

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Paperhanger

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Elias Rottman

14. MOTHER'S MAIDEN NAME: Eva Kirschenbaum

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W I

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Mrs. Jennie Shuham ADDRESS: 6957 Brookmill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis Ht Dis — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

(B) Hypertension Ht Dis — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1958 19 to 4/12 1967, that (I) (we) last saw the deceased alive on 4/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sol. Smith M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/14/67

23C. PHYSICIAN'S NAME (Type): M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 16/67

24C. NAME of CEMETERY or CREMATORY: Rodemer Veteran

24D. LOCATION (City, town, or county) (State): Rosedale, Md

25A. DATE RECVD BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Sol Shuman & Bro Inc

ADDRESS: 600 East Lexington

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-450

BIRTH NO. 67 3887

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3887

1. NAME OF DECEASED (Type or Print): SARAH BLOOM

2. DATE AND HOUR PRONOUNCED DEAD: April 12, 1967 6:50 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2606 Ulman Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12

D. STREET ADDRESS (If rural, give location): 2606 Ulman Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH:

9. AGE (In years last birthday): [redacted] 74

If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Yaffe

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKnown

17. INFORMANT: Mrs. Frank Glazer

ADDRESS: 3203 Smith Avenue #8

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/12/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4/13/67

23C. NAME of CEMETERY or CREMATORY: Chizuk Amuno (Arlington)

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

24B. NAME OF REGISTRAR: Robert E. Fankhauser

24C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reist., Rd.

VS 151-REV. 1/1965

6 7 0 0 3 8 9 5

T-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3888 Registered No. 67 3888

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MOLLIE TALLES

2. DATE AND HOUR OF DEATH: 5 A.M. 4/15/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4000 Fallstaff Road, Apt 1A

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 4000 Falstaff Rd
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 15 Md 27-20
D. STREET ADDRESS (If rural, give location):

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 10-25-1899
9. AGE (In years last birthday): 67
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman ~~[illegible]~~ Schoen
14. MOTHER'S MAIDEN NAME: Gertrude ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-28-7305
17. INFORMANT: Mr. Ely Talles, 4000 Fallstaff Road, Apt 1A
ADDRESS:

MEDICAL CERTIFICATION

1B. 4.20.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH: ~~Immediate~~

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on March 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Milton B Kress M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/15/67
23C. PHYSICIAN'S NAME (Type): MILTON B. KRESS M.D.
23D. ADDRESS: Medical arts Bldg Balto Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/16/67
24C. NAME of CEMETERY or CREMATORY: Beth Thilah
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., 6010 Reist., Rd.
ADDRESS:

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 8 8 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3889 Registered No. 67 3889

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOUIS GROSSFELD

2. DATE AND HOUR OF DEATH: APRIL 14, 1967 1 55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 HOUSEIN THE PINES, BELVEDERE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 28-41
D. STREET ADDRESS (If rural, give location): 5501 CHANDLER AVENUE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 1-3-1886
9. AGE (In years last birthday): 81
If Under 1 Yr. Months Days Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PROPRIETOR
10B. KIND OF BUSINESS OR INDUSTRY: HOLLAND CLEANERS
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MEYER GROSSFELD
14. MOTHER'S MAIDEN NAME: SHANDEE ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-09-5216A
17. INFORMANT: MRS. LENA GROSSFELD, 5501 CHANDLER AVENUE #7
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarct left lung — INTERVAL BETWEEN ONSET AND DEATH: 2 wk

DUE TO

(B) Pneumonia

DUE TO

(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Stroke rt side — 2 wks

Senility

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 1 1967 to April 14 1967, that (I) (we) last saw the deceased alive on April 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr Thos G Ablott M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-14-67
23C. PHYSICIAN'S NAME (Type): DR. THOMAS G. ABLOTT M.D.
23D. ADDRESS: 4509 LIBERTY HEIGHTS AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/16/67
24C. NAME of CEMETERY or CREMATORY: PROGRESSIVE RUDOMER RUSS
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., 6010 REIST., RD.
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-U51

BIRTH NO. 67 3890

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3890

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Anna ARNOFF

2. DATE AND HOUR OF DEATH: 4-14-1967 | 2,25 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 LEVINDALE AGED HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): Levindale Nursing Home & Infirmary

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: [redacted]
9. AGE (In years last birthday): [redacted] 75 — If Under 1 Yr. Months, Days; If Under 24 Hrs. Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Benjamin Geister ?
14. MOTHER'S MAIDEN NAME: ? Rasha ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Sarah Silverman (Daughter) — ADDRESS: 5424 Gist Ave.

MEDICAL CERTIFICATION

1B. 4 22 1

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Embolism — 45 minutes

DUE TO

(B) ASCVD — Years

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-28- 1966 to 4-14- 1967, that (I) (we) last saw the deceased alive on 4-14- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jose Ardaiz — M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-14-67
23C. PHYSICIAN'S NAME (Type): Jose ARDAIZ — M.D.
23D. ADDRESS: 5912 Cross Country Blvd. Baltimore 21215

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/16/67
24C. NAME of CEMETERY or CREMATORY: Babroisher Beneficial Circle
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

3898

T-640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3891 Registered No. 67 3891

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Thurlow Perly

2. DATE AND HOUR OF DEATH: 16 APR 67 | 6:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: USA
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 5 Tamworth Rd

5. SEX: M | 6. RACE: W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED | 8. DATE OF BIRTH: 3-4-9[illegible] | 9. AGE (In years last birthday): 75 | If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired- Vice President Farm Equipment
10B. KIND OF BUSINESS OR INDUSTRY: John Deere Company
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leonard Thurlow
14. MOTHER'S MAIDEN NAME: Ellen Ferrer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 213-03-6783 A
17. INFORMANT: Mrs. Elizabeth Thurlow ADDRESS: same address

MEDICAL CERTIFICATION

18. 4518

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Aortic Aneurysm Ruptured
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 16 Apr 67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ruptured Aneurysm
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 16 Apr 67 19 67 to 16 Apr 19 67, that (I) (we) last saw the deceased alive on 16 Apr 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 16 Apr 67
23C. PHYSICIAN'S NAME (Type): M. B. Flynn M.D.
23D. ADDRESS: Maryland General Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/1967
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: Balto. Md. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-267

BIRTH NO. 67 3892

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3892

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Judith Faye Rogers

2. DATE AND HOUR OF DEATH: April 17, 1967 | 11:05 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Public Health Service Hospital Baltimore, Maryland

28

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Arizona

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Tuscon

V-02

D. STREET ADDRESS (If rural, give location): 7230 Eli Drive

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Fem	White	Mar	May-9-1938	28				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	--	Texas	USA

13. FATHER'S NAME: David [illegible] Weisblat

14. MOTHER'S MAIDEN NAME: Ida Babior

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Records-U.S.P.H.S. Hospital, Baltimore, Md.

ADDRESS:

MEDICAL CERTIFICATION

1B. 204.31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Acute myelogenous leukemia

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 21 19 66 to April 17 19 67, that (I) (we) last saw the deceased alive on April 17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE: James M Weaver M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: April 18, 1967

23C. PHYSICIAN'S NAME (Type): James M. Weaver, Medical Director M.D.

23D. ADDRESS: U.S.P.H.S. Hospital, Baltimore, Md. 21211

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Removal	4/18/1967		Dallas, Texas

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 20 1967	Robert E. Farley M.D.	Wm. P. Tickner & Sons	Baltimore, Md. North Ave.

VS 150-REV. 1/1/65

A-130

BIRTH NO. 67 3893

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3893

1. NAME OF DECEASED (Type or Print): Jeannette L. Abbott

2. DATE AND HOUR OF DEATH: 4-18-67 12:15 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: Bolton Hill Nursing Center (FULL NAME OF HOSPITAL OR INSTITUTION) (If not in hospital or institution, give street address or location) 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 1662 Waverly Way 21212

5. SEX: Female
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 5/19/1882
9. AGE (In years last birthday): 84
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier - Retired
10B. KIND OF BUSINESS OR INDUSTRY: Lord Baltio. Hotel
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles H. Hildebrandt
14. MOTHER'S MAIDEN NAME: Anna Himpel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-16-2479
17. INFORMANT: Mrs. Frances H. Gill
ADDRESS: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B) Cerebral insufficiency — years

DUE TO

(C) Peripheral ulcers — 1 mo

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Diabetes generalized — years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 4/1/ 19 67 to 4/18 19 67, that (I) (we) last saw the deceased alive on 4/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): ALLAN H. MACHT M.D.
23D. ADDRESS: 2 EAST READ ST 21202

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/1967
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Wm J. Tribuer & Sons
ADDRESS: Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3894

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3894

1. NAME OF DECEASED (Type or Print): JOHN A. HILL, Sr.

2. DATE AND HOUR OF DEATH: 4/18/67 | 805 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: —
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-03
D. STREET ADDRESS (If rural, give location): 1810 THOMAS AVE.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 5/2/84
9. AGE (In years last birthday): 82
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 218-09-9139
17. INFORMANT: CHART — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 dy.

DUE TO

(B) Peripheral vascular disease — 7 yrs

DUE TO

(C) Diabetes mellitus — 9 yrs

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pneumonia

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14 19 67 to 4/18 19 67, that (I) (we) last saw the deceased alive on 4/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sheldon Frank M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): SHELDON FRANK M.D.
23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/22/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fasbaum
25C. FUNERAL DIRECTOR: Wm. Tickner Sons
ADDRESS: Balto. Md. Northern

VS 150-REV. 1/1/65

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3895 Registered No. 67 3895

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA SCHOENBECK

2. DATE AND HOUR OF DEATH: APRIL 17, 1967 | 4:42 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MARYLAND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: —
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-01
D. STREET ADDRESS (If rural, give location): 3955 CLOVES HILL ROAD

5. SEX: FEMALE
6. RACE: CAUC.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: MAR. 23, 1883
9. AGE (In years last birthday): 84
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: THEODORE OPPENHEIMER
14. MOTHER'S MAIDEN NAME: Emily ~~Wolbaum~~
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Paul M. Doctor, DAUGHTER
ADDRESS: SAME AS ABOVE

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221
(A) CONGESTIVE HEART FAILURE — 3 YEARS
DUE TO
GENERALIZED ATHEROSCLEROTIC
(B) CARDIOVASCULAR DISEASE — 10 YEARS+
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that ~~(I)~~ (this hospital) attended the deceased from MARCH 27, 1967 to APRIL 17, 1967, that (I) (we) last saw the deceased alive on APRIL 17, 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: John C. Dumler, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: April 17, 1967
23C. PHYSICIAN'S NAME (Type): JOHN C. DUMLER, JR. M.D.
23D. ADDRESS: UNIVERSITY OF MARYLAND HOSPITAL 22 S. GREENE ST. BALT., MD. 21201

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/1967
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fetham
25C. FUNERAL DIRECTOR: Wm. P. Tilghman & Sons
ADDRESS: Balto. Md. Smithsburg, Pa.

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3896 Registered No. 67 3896

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Languille Mrs Sarah G.

2. DATE AND HOUR OF DEATH: 4/16/67 6 10 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 Church Home and Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 3035 Shannon dr.

5. SEX: F. 6. RACE: W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 8/27/1880 9. AGE (In years last birthday): 86. If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker. 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY? American.

13. FATHER'S NAME: W. Josiah Bromwell. 14. MOTHER'S MAIDEN NAME: Sarah Shenton.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): None 16. SOCIAL SECURITY NO. 218-52-3662

17. INFORMANT: Chart ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Pneumonia, Massive rt. lobe — 2 days

(B) DUE TO: A.S.H.D. with C.H.F.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-13 1967 to 4-16 1967, that (I) (we) last saw the deceased alive on 4-16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jose G. Ortiz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4-16-67

23C. PHYSICIAN'S NAME (Type) M.D. 23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/19/1967 24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967 25B. NAME OF REGISTRAR: Robert E. Fasbury M.D. 25C. FUNERAL DIRECTOR: Wm. J. Tilghman & Sons ADDRESS: Baltimore, Md. North & Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 3897

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3897

1. NAME OF DECEASED (Type or Print): LOSINSKI, STEPHEN JOHN

2. DATE AND HOUR OF DEATH: APRIL 18, 1967 2:10A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 25-04

D. STREET ADDRESS (If rural, give location): 3621 TENTH ST. 21225

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11-01-91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY: B & O RAILROAD

11. BIRTHPLACE (State or foreign country): UNKNOWN

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: DOMINICK LOSINSKI (DEC'D)

14. MOTHER'S MAIDEN NAME: MARY (UNKNOWN) (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST. AGNES HOSPITAL RECORDS ADDRESS:

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 587.01

CAUSE OF DEATH

(A) Pulmonary Embolus

DUE TO

(B) hemorrhagic Pancreatitis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCUD

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 31 19 67 to APRIL 18 19 67, that (I) (we) last saw the deceased alive on APRIL 18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George S. Patrick M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): GEORGE S. PATRICK M.D.

23D. ADDRESS: CATON AND WILKENS AVE. BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/21/67

24C. NAME of CEMETERY or CREMATORY: Holy Cross Cem

24D. LOCATION (City, town, or county): A A Co (State): Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: McCully F H

ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SAB-47-52-94 K-452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3898

BIRTH NO. 67 3898

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROSE V. ROYLANCE

2. DATE AND HOUR OF DEATH: 4-17-67 | 2 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Anne Arundel Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ANNAPOLIS 52-10

D. STREET ADDRESS (If rural, give location): 805 WEST ST. 21401

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: 3-28-23

9. AGE (In years last birthday): 44

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10B. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): HAWAII

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN VEVEIROS

14. MOTHER'S MAIDEN NAME: VIRGINA CORREIA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: HOSP. CHART

ADDRESS: Records: BCH-4940 Eastern Avenue 21224

MEDICAL CERTIFICATION

1B. 164X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Mediastinal Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/19 1967 to 4/17 1967, that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bruce G. Whipple M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-17-67

23C. PHYSICIAN'S NAME (Type): Bruce G. Whipple M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-19-1967

24C. NAME of CEMETERY or CREMATORY: CEDAR BLUFF CEM.

24D. LOCATION (City, town, or county) (State): ANNAPOLIS A.A.Co. MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: JOHN M. TAYLOR & SONS

ADDRESS: ANNAPOLIS MD

VS 150-REV. 1/1/65

67 0 0 3 9 0 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3899 Registered No. 67 3899

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gerlach, Frances K.

2. DATE AND HOUR OF DEATH: 4/15/67 6:1 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto, #21224 26-05
D. STREET ADDRESS (If rural, give location): 449 S. Dean St.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 1/22/99
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Walinski
14. MOTHER'S MAIDEN NAME: Anna Stalings

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): N
If yes, give war or dates of service: —
16. SOCIAL SECURITY NO.: 215-09-1896
17. INFORMANT: JAMES S. WALINSKI
ADDRESS: 1321 1/2 SPRING AV BALTO. 06. MD.

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma, Stomach — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/15 1967 to 4/15 1967, that (I) (we) last saw the deceased alive on 4/15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel C. Wilkerson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/15/67
23C. PHYSICIAN'S NAME (Type): Daniel C. Wilkerson M.D.
23D. ADDRESS: 421 Register Ave Balto 12

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEM.
24D. LOCATION (City, town, or county) (State): 7301 GERMAN HILL RD. BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fochman
25C. FUNERAL DIRECTOR: Charles S. Geiler
ADDRESS: 901 S. CONKLING ST. BALTO., 21224, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
S-560

BIRTH NO. 67 3900

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3900

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY M. SKINNER

2. DATE AND HOUR PRONOUNCED DEAD: April 18, 1967 3:05 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06

D. STREET ADDRESS (If rural, give location): 820 Rosedale Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	June 28, 1909	57				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe-Fitter	Maryland Drydock	New York	USA

13. FATHER'S NAME: Albert Skinner

14. MOTHER'S MAIDEN NAME: Mary Schwalenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213031830

17. INFORMANT: Helen A. Skinner ADDRESS: 820 Rosedale Ave

MEDICAL CERTIFICATION

18. #2010

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/21/67	Gardens of Faith Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 20 1967	Robert E. Farley M.D.	Philip E. Crach	1211 Chesaco Ave.

VS 151-REV. 1/1/65

1967 0003908

M-250

BIRTH NO. 67 3901

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3901

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROLAND MASON

2. DATE AND HOUR PRONOUNCED DEAD: April 18, 1967 7:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1730 Bolton Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01

D. STREET ADDRESS (If rural, give location): 1730 Bolton Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	single	6-27-28	36				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: M. E. Mason

14. MOTHER'S MAIDEN NAME: Martha Chapman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212269647

17. INFORMANT: Martha Tibbs ADDRESS: 1915 McCulloh St.

MEDICAL CERTIFICATION

18. E98/X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wounds of chest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1730 Bolton Street 14-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): April 18, 1967 7:15 P.m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Shot in chest

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: R S Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

DATE SIGNED: 4-19-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-22-67	Arbutus Mem. Park	Arbutus Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 20 1967	Robert E. Fackenna	Kelson Funeral Home	1348 Calhoun St.

VS 151-REV. 1/1/65

N875 4 9 6 7 0 0 0 3 9 0 9

S-3131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3902 Registered No. 67 3902

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Stepto

2. DATE AND HOUR OF DEATH: 4-18-67 | 10:25 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, Inc.

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 13-01

D. STREET ADDRESS (If rural, give location): 2446 Callow Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	1-4-16	51 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchantile Safe Deposit & Trust Company		Pennsylvania	U. S. A.

13. FATHER'S NAME: James Stepto

14. MOTHER'S MAIDEN NAME: Mae

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 206054107

17. INFORMANT: Cecelia Stepto - wife

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 150 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the esophagus

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 17, 19 67 to April 18, 19 67, that (I) (we) last saw the deceased alive on April 18, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-18-67

23C. PHYSICIAN'S NAME (Type): C. Laredo M.D.

23D. ADDRESS: 1514 Division Street Balto., Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-24-67	Balto. National Cem.	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT. APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Kelson Funeral Home

ADDRESS: 1348 Calhoun St.

VS 150-REV. 1/1/65

967000 3910

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 4/16 67 3903 Registered No. 67 3903

M.E. CASE NO. C163

1. NAME OF DECEASED (Type or Print) Charlotte Colvert / CHARLOTTE A. COVERT

2. DATE AND HOUR OF DEATH 4-16-67 11.00P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7-05

D. STREET ADDRESS (If rural, give location) 2021 ASHLAND AVENUE 21205

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	MARRIED	5-30-99	67		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CHARLES E. GROSS

14. MOTHER'S MAIDEN NAME ANNA N. COON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213541802

17. INFORMANT Robert T. Covert ADDRESS 2021 E. Ashland Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 / E260X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO Probable pulmonary embolus

(B) DUE TO CA 7

(C) HBCVD

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/15 19 67 to 4/16 19 67, that (I) (we) last saw the deceased alive on 4/16/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Kenneth L. Brigham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 4/16/67

23C. PHYSICIAN'S NAME (Type) Kenneth L. Brigham M.D.

23D. ADDRESS Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 4/20/67

24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. APR 20 1967

25B. NAME OF REGISTRAR R. L. E. Fahrney

25C. FUNERAL DIRECTOR Philip F. Quach ADDRESS 1211 Chesaco Ave.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1 10 38 08 M COVERT, CHARLOTTE

2-100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3904 Registered No. 67 3904

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Stella May Zepp

2. DATE AND HOUR OF DEATH: April 16 1967 | 11:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-08
D. STREET ADDRESS (If rural, give location): 4112 Falls Rd

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Dec 31 1884
9. AGE (In years last birthday): 82
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dillow
14. MOTHER'S MAIDEN NAME: Clara E

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212075314
17. INFORMANT: Maurice E Zepp
ADDRESS: 4112 Falls Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Hypertension cardiovascular disease — 15 yrs.
DUE TO
(B) Cerebral vascular accident — 4 mo.
DUE TO
(C) Osteoarthritis of spine — 3 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from February 17, 1965 to April 16, 1967, that (I) (we) last saw the deceased alive on April 12, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Apr. 17, 1967
23C. PHYSICIAN'S NAME (Type): Lloyd Saylor M.D.
23D. ADDRESS: 3902 Greenmount Ave Balto

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: Immanuel Cem
24D. LOCATION (City, town, or county) (State): Manchester Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Lawley, M.D.
25C. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Rd 21211

1967 Bernard W. Burgee Jr.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3905 Registered No. 67 3905

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Maud C. Eakle

2. DATE AND HOUR OF DEATH: April 14, 1967 | 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-06

D. STREET ADDRESS (If rural, give location): 818 Wellington Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 4 Sept 1889

9. AGE (In years last birthday): 77

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weaver

10B. KIND OF BUSINESS OR INDUSTRY: Cotton Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. Eakle

14. MOTHER'S MAIDEN NAME: Barbara E Hood

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 213 03 4223

17. INFORMANT: W. J. Thompson ADDRESS: 6408 Pinehurst Rd

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Coronary Thrombosis

DUE TO

(B) arteriosclerotic Cardiovascular disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: sudden

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/12 1952 to 4/14 1967, that (I) (we) last saw the deceased alive on 4/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Reuben Hoffman M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): Reuben Hoffman M.D.

23D. ADDRESS: 846 W 36th St

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-18-67

24C. NAME of CEMETERY or CREMATORY: Cathedral

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: Burger Funeral Home ADDRESS: 3631 Falls Rd 21211

Burger, Jr.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-437

BIRTH NO. 67 3906

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3906

1. NAME OF DECEASED (Type or Print): HARRY N. SCHULTZ

2. DATE AND HOUR OF DEATH: 4-18-67. 7:06 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE. 27-05

D. STREET ADDRESS (If rural, give location): 3008 Royston Ave.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED.

8. DATE OF BIRTH: 12-24-1895

9. AGE (In years last birthday): 71

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Louis SCHULTZ.

14. MOTHER'S MAIDEN NAME: MARY CLOMAN.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-05-9192

17. INFORMANT: Emma Mae Schultz

ADDRESS: 3008 Royston Ave.

MEDICAL CERTIFICATION

18. ~~545~~ I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary infarct. — unk.

DUE TO

(B) Post sub-total Gastrectomy & Billroth II — 2 days.

~~DUE TO~~

(C) Bacteremia & peritonitis — unk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-18-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: GI Bleeding

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-15 1967 to 4-18 1967, that (I) (we) last saw the deceased alive on 4-18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sedon L Hawbaker M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-18-67.

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/22/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Fabian M.D.

25C. FUNERAL DIRECTOR: Robert C. Altenburg Funeral Home, Inc.

ADDRESS: 6009 Harford Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-06-19 IB B-653 67 3907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3907

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERTA BRYANT
ALBERTA BRYANT

2. DATE AND HOUR OF DEATH: 4/19/67 1:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 709 DRUID HILL AVENUE, BALTIMORE, MD #21201

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 1-2-99
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): NORTH CAROLINA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FRANK ANTHONY
14. MOTHER'S MAIDEN NAME: MARY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE,
ADDRESS: #21224

MEDICAL CERTIFICATION

1B. 146X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Nasopharyngeal Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-9 19 66 to 4-19- 19 67, that (I) (we) last saw the deceased alive on 4-19- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: D. Tarsy. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/19/67

23C. PHYSICIAN'S NAME (Type): DR. D. TARSY M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD. #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/21/67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave.

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3908 Registered No. 67 3908

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM S CONNELLY William S. Connelly

2. DATE AND HOUR OF DEATH 4/19/67 4/19/67 1:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mayland General Hosp

827 Linden Ave. Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto - Dundalk

D. STREET ADDRESS (If rural, give location) 3431 Liberty Parkway

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH 4/24/15 9. AGE (In years last birthday) 51 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur 10B. KIND OF BUSINESS OR INDUSTRY Delivery of Baltimore 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Connelly 14. MOTHER'S MAIDEN NAME Anna Wolfe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) yes (If yes, give war or dates of service) Army WWII 16. SOCIAL SECURITY NO. 216-01-5924

17. INFORMANT (Wife) Mrs. Yolanda Connelly, 3431 Liberty Pkwy. ADDRESS Dundalk, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anaplastic Carcinoma of lung

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/15 1967 to 4/19 1967, that (I) (we) last saw the deceased alive on 4/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Ronald Goldner M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED 4/19/67

23C. PHYSICIAN'S NAME (Type) Ronald Goldner M.D. 23D. ADDRESS 827 Linden Ave., Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/22/67 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE RECEIVED HEALTH DEPT. APR 20 1967 25B. NAME OF REGISTRAR Robert E. Tarkington 25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave, Dundalk, Md. ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 003916

49-00-62 IIB

E-400

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3909

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3909

1. NAME OF DECEASED (Type or Print): EMMA ELEY

2. DATE AND HOUR OF DEATH: 4/18/67 10 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

10-02

D. STREET ADDRESS (If rural, give location): 914 ABBOTT COURT - #21202

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: 12-25-02

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN

14. MOTHER'S MAIDEN NAME: EMMA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

If yes, give war or dates of service:

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE, #21224

ADDRESS:

MEDICAL CERTIFICATION

1B. 2042

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Chronic Myelocytic Leukemia — 4 y.

DUE TO

(B) Anemia ? Primary — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — ASCVD — 10 y.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/2 1967 to 4/18 1967, that (I) (we) last saw the deceased alive on 4/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Clayton Moravec M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): DR. CLAYTON MORAVEC M.D.

23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD. #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/22/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Jackson

25C. FUNERAL DIRECTOR: Joseph G. Lentz Jr.

ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/66

54-40

BIRTH NO. 67 3910

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3910

1. NAME OF DECEASED (Type or Print): HALL, LILLIAN M

2. DATE AND HOUR OF DEATH: APRIL 19, 1967 | 1:30AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: ST. AGNES HOSPITAL

(If not in hospital or institution, give street address or location): WILKENS & CATON AVES.

BALTO. 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY: ☒ 28-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21229

D. STREET ADDRESS (If rural, give location): 220 Mallow Hill Rd. - ~~98-SMITHWOOD-AVE.~~

5. SEX: FEMALE

6. RACE: CAUCASION

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 02-11-75

9. AGE (In years last birthday): 92

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE ~~HEDDRXXX~~ HEDDRICK DEC'D

14. MOTHER'S MAIDEN NAME: MELVINA BRYAN DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNKNOWN

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-46-1560

17. INFORMANT: ST. AGNES RECORDS; WILKENS & CATON AVES. #29

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.0 I-E 903.7

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ~~5 days~~

~~Fractured hip~~

DUE TO

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture, Rt. Femur — 5 days.

CERTIFICATION APPROVED BY: M.D. OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (notify medical examiner): yes

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Nursing home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 98 Smithwood Ave. Summit Nursing home

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 4 13 1967

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? Patient fell to floor while walking

22. I certify that (I) (this hospital) attended the deceased from APRIL 17 19 67 to APRIL 19 19 67, that (I) (we) last saw the deceased alive on APRIL 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Carl H. Matthey M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-19-1967.

23C. PHYSICIAN'S NAME (Type): CARL H. MATTHEY M.D. M.D.

23D. ADDRESS: WILKENS & CATON AVES., BALTO. 29, MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-21-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

VS 150-REV. 1/1/65 N 821.8 3918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-621

BIRTH NO. 67 3911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3911

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH ARTHUR GRISBACH

2. DATE AND HOUR OF DEATH: APRIL 17,1967 | 6 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1429 Holbrook Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21202 9-09

D. STREET ADDRESS (If rural, give location): 1429 Holbrook Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Aug.1,1894	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic Balto, Trans.Co,Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Grisbach

14. MOTHER'S MAIDEN NAME: Cicila Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218 05 2107 A.

17. INFORMANT: Mrs Amelia E. Grisbach

ADDRESS: 1429 Holbrok St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 422.11

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO ↓

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Arteriosclerotic C.V. Disease — 5 yr.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema — 3 yr

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	NO	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ —

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from — 19 60 to 4-17 19 67, that (I) (we) last saw the deceased alive on 4-14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J Duer Moores M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): J. Duer Moores M.D.

23D. ADDRESS: 3105 Belair Road Balto. Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/20/67	Most Holy Redeemer Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Fookes M.D.

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC.

ADDRESS: BALTIMORE MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
17-616

BIRTH NO. 67 3912

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3912

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Marie ANNA HERBERT

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 7:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4903 Aberdeen Avenue #6

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 8/23/92
9. AGE (In years last birthday): 74
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10B. KIND OF BUSINESS OR INDUSTRY: Bugle Laundry
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bartholmew Schriefer
14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 217-26-4667
17. INFORMANT: Mary Reynolds, Dght., ADDRESS: 4903 Aberdeen Ave. #6

MEDICAL CERTIFICATION

1B. 443 X 4 2816.4

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia complicating cerebral infarcts
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive and arteriosclerotic cardiovascular disease
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebrocranial injuries and fracture of left tibia

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Edison Avenue and Biddle Street
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2-12-67 11:58 A. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Passenger in auto-auto collision

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/20/67
23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
24B. NAME OF REGISTRAR: Robert E. Foley M.D.
24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Brehms Lane #13

VS 151-REV. 1/1/65

N 8 31 6 2 7 0 0 3 9 2 0

B-10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3913 Registered No. 67 3913

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLENE R. BOPP

2. DATE AND HOUR OF DEATH: 4-18-67 | 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto - 26-02
D. STREET ADDRESS (If rural, give location): 4311 Sheldon Ave #13

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	never married	12-22-55	11		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: John E Bopp.

14. MOTHER'S MAIDEN NAME: Stephanie Salajczyk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		none	John Bopp, Father,	4311 Sheldon Ave. #13

MEDICAL CERTIFICATION

CAUSE OF DEATH

		INTERVAL BETWEEN ONSET AND DEATH
1B. 95431 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Congestive Heart Failure	2 days ?
ANTECEDENT CAUSES	DUE TO (B) Congenital Heart Disease	11 yrs.
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	DUE TO (C) Down's Syndrome	11 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Pneumonia (possibly staph)	2 days ?

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/18 1967 to 4/18 1967, that (I) (we) last saw the deceased alive on 4/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert R. Hotthaus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/21/67	Holy Rosary Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 20 1967	Robert E. Fosby M.D.	Schimunek Funeral Home	3331 Brehms Lane #13

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 9 2 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3914 Registered No. 67 3914

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Goetz, Henry John

2. DATE AND HOUR OF DEATH: 4/18/67 8:44 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-02

D. STREET ADDRESS (If rural, give location): 2728 E. MONUMENT STREET 21205

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-10-99

9. AGE (In years last birthday): 67 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Drive

10B. KIND OF BUSINESS OR INDUSTRY: American Oil Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Goetz

14. MOTHER'S MAIDEN NAME: Barbara Bothe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 216-09-6782

17. INFORMANT: Minnie (nee Schelle) Goetz, wife, above ADDRESS:

MEDICAL CERTIFICATION

18. 33/X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro-vascular accident — 30 hours

DUE TO

(B)

DUE TO

(C) Hypertension — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/17 1967 to 4/18 1967, that (I) (we) last saw the deceased alive on 4/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sherrard L. Hayes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): SHERRARD L. HAYES M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/21/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Ralph E. Fahrney

25C. FUNERAL DIRECTOR: Schimunek Funeral Home ADDRESS: 2601-03-05 E. Madison Street #5

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-352

BIRTH NO. 67 3915

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3915

1. NAME OF DECEASED (Type or Print): Lillian E. Adams

2. DATE AND HOUR OF DEATH: April 18, 1967 | 11:30 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen. Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): Rt. 16 Box 473 A-1 #20

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 12-25-03

9. AGE (In years last birthday): 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Balto.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Dandy

14. MOTHER'S MAIDEN NAME: Ella Craig -

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-10-4903

17. INFORMANT: James Adams - Same, husband, above

ADDRESS

MEDICAL CERTIFICATION

18. 163X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) CARCINOMA OF LUNG WITH METASTASIS

DUE TO

(B) TO BRAIN, LIVER

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 13 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1967 to April 18 1967, that (I) (we) last saw the deceased alive on April 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rolendon Sabundayo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: April 18, 1967

23C. PHYSICIAN'S NAME (Type): ROLENDO M SABUNDAYO M.D.

23D. ADDRESS: Maryland Gen. Hospital, Balto.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/22/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Fisher M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home

ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F 450

BIRTH NO. 67 3916

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3916

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): PETER FOLAN

2. DATE AND HOUR OF DEATH: 4-19-67 | 4 35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21214 27-01
D. STREET ADDRESS (If rural, give location): 4613 HARCOURT ROAD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 08-01-18
9. AGE (In years last birthday): 48
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Gas & Electric Co.
11. BIRTHPLACE (State or foreign country): IRELAND
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: MICHAEL FOLAN
14. MOTHER'S MAIDEN NAME: NORA FOLAN Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-28-1871
17. INFORMANT: Mrs. Marie A. Folan
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 434.1
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction
DUE TO
(B) Acute bronchopneumonia
DUE TO
(C) Congestive heart failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

A. Hypolito, M.D.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-18 1967 to 4-19 1967, that (I) (we) last saw the deceased alive on 4-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4-19-67
23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY, M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/22/67.
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

H-322

BIRTH NO. 67 3917

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3917

1. NAME OF DECEASED (Type or Print): Joseph Hodges

2. DATE AND HOUR OF DEATH: April 18, 1967. 7 45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3300 Gibbons Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: 27-44

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214

D. STREET ADDRESS (If rural, give location): 3300 Gibbons Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 23, 1880.

9. AGE (In years last birthday): 86

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lead Burner

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles F. Hodges

14. MOTHER'S MAIDEN NAME: Sarah McPherson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 218-05-7967

17. INFORMANT: Mrs. Norma Haught ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Cardio Vascular Disease with Cardiac Decompensation — ~~[illegible]~~ 14 days

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Chronic Bronchitis & Emphysema — 20 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Recurrent Pneumonitis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from ~~[illegible]~~ May 1954 to April 1967, that (I) (~~we~~) last saw the deceased alive on 17 April 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Thomas J. Brennan M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 19 April 1967

23C. PHYSICIAN'S NAME (Type): Thomas J. Brennan M.D.

23D. ADDRESS: 5217 Harford Road Balto Md 14

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/21/67.

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: [illegible] M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-365

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3918 Registered No. 67 3918

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT J. ~~XXXXXX~~ STURM

2. DATE AND HOUR OF DEATH: April 19, 1967. 5:15 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5404 Elsrode Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 3706

D. STREET ADDRESS (If rural, give location): 5404 Elsrode Avenue

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	August 22, 1893.	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired-Hoisting Eng.	Arundel Corp.	Maryland	USA

13. FATHER'S NAME: William Sturm

14. MOTHER'S MAIDEN NAME: Kate Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-5335

17. INFORMANT: Mrs. Edna E. Sturm ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

(B) Arteriosclerotic C.V.D.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1963 to April 19 1967, that (I) (~~we~~) last saw the deceased alive on Feb. 22 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: J. Henry Haase M.D. — M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/19/67.

23C. PHYSICIAN'S NAME (Type): J. Henry Haase M.D.

23D. ADDRESS: M.D. 7512 E. Lake Springs Lane Balto. 14, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/22/67.

24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 3919

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3919

1. NAME OF DECEASED (Type or Print): RUTH TAPMAN

2. DATE AND HOUR OF DEATH: April 19, 1967. 6:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3104 Hillcrest Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: 27-05

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21234

D. STREET ADDRESS (If rural, give location): 3104 Hillcrest Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: April 6, 1903.

9. AGE (In years last birthday): 64

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George C. Tapman

14. MOTHER'S MAIDEN NAME: Minnie E. Thompson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-44-7901

17. INFORMANT: Mr. Edward W. Tapman ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 290.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Congestive Heart Failure

DUE TO

(B) Pernicious anemia

DUE TO

(C) Hemolytic "

Enlarge liver and Spleen

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1964 to Present date 19 ..., that (I) (we) last saw the deceased alive on April 14th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did not) view the body after death.

23A. SIGNATURE: Manuel Sodaro M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/20/67

23C. PHYSICIAN'S NAME (Type): MANUEL SODARO MD M.D.

23D. ADDRESS: 4624 York Road · Balto Md 21212

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 4-22-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3920 Registered No. 67 3920

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gibson Mrs Frances

2. DATE AND HOUR OF DEATH: Apr. 19, 1967 6-30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Keswick

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Keswick B. COUNTY: 13-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Maryland

D. STREET ADDRESS (If rural, give location): 400 W. 40th St.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 10-17-1877

9. AGE (In years last birthday): 89

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10B. KIND OF BUSINESS OR INDUSTRY: Travelers Aid

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Abbott Bryant

14. MOTHER'S MAIDEN NAME: Carrie Ida Christiel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-30-9391

17. INFORMANT: Margaret R. Hundley R.N. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 8 JAN 1964 to 19 APR 1967, that (I) (~~we~~) last saw the deceased alive on 19 APR 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Aubrey D. Richardson M.D. Attending Phys. ☐ Med. Director ☑ Staff Phys. ☐

23B. DATE SIGNED: 20 Apr 1967

23C. PHYSICIAN'S NAME (Type): Aubrey D. Richardson M.D.

23D. ADDRESS: 700 W. 40th Street

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-21-1967

24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State): Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: P. O. [illegible]

25C. FUNERAL DIRECTOR: Henry W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md. 21212

VS 150-REV. 1/1/65

3920

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3921 Registered No. 67 3921

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SHEELER, WILLIAM LEO

2. DATE AND HOUR OF DEATH: 4-19-67 at 7:55 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 NORTH CHARLES GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-48

D. STREET ADDRESS (If rural, give location): 6303 WEIDNER AVE 21212

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8/23/90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - ELECTRICIAN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK SHEELER

14. MOTHER'S MAIDEN NAME: JENNY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 213-10-7465

17. INFORMANT: MRS. RUTH L. SHEELER

ADDRESS: (SAME)

MEDICAL CERTIFICATION

1B. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CEREBRA VASCULAR ACCIDENT

DUE TO

(B) RENAL INSUFFICIENCY

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-17 1967 to 4-19 1967, that (I) (we) last saw the deceased alive on 4-19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alejandro Montoya M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-19-67

23C. PHYSICIAN'S NAME (Type): ALEJANDRO MONTOYA M.D.

23D. ADDRESS: NORTH CHARLES GENERAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/22/1967

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Pk.

24D. LOCATION (City, town, or county) (State): Parkville, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Foxley M.D.

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto. 12, Md.

0 3 9 2 9

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-36b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3922 Registered No. 67 3922

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles H. Stricker — Charles Stricker

2. DATE AND HOUR OF DEATH: 4/17/67 | 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital — Mercy Hospital

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 21218 — 9-04

D. STREET ADDRESS (If rural, give location): 3022 Mathews St.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 10/19/1889

9. AGE (In years last birthday): 77

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Station Manager

10B. KIND OF BUSINESS OR INDUSTRY: American Oil Co.

11. BIRTHPLACE (State or foreign country): Balto. Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Stricker

14. MOTHER'S MAIDEN NAME: Mary Hoen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-6277

17. INFORMANT: Charles M. Stricker

ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Atherosclerotic heart disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Old myocardial infarction

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/15 1967 to 4/17 1967 that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis E. Grenzer M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): Louis E. Grenzer M.D.

23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/21/1967

24C. NAME of CEMETERY or CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Baltimore County Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Henry W. Jenkins — ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3923 Registered No. 67 3923

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Grace F. Civish

2. DATE AND HOUR OF DEATH: 4/20/67 1:30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1676 Burnwood Rd.

5. SEX: F
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1-29-1908
9. AGE (In years last birthday): 59
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph M. Fowler
14. MOTHER'S MAIDEN NAME: Florence Sapp

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: --
17. INFORMANT: John C. Civish
ADDRESS: Same

MEDICAL CERTIFICATION

18. 200.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Reticulum Cell Sarcoma — July 1966
DUE TO
(B) Of the thyroid gland with metastasis to the mediastinum — Several days
DUE TO
(C) Tracheal compression and obstruction due to the sarcoma

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 19 66 to April 20th 19 67, that (I) (we) last saw the deceased alive on April 20th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George H Beck M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/20/67
23C. PHYSICIAN'S NAME (Type): GEORGE H. BECK George H. Beck M.D.
23D. ADDRESS: 6012 HARFORD ROAD BALTIMORE, MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-22-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-632

BIRTH NO. 67 3924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3924

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANTOINETTE KORDISZEWSKI

2. DATE AND HOUR OF DEATH: 4-18-1967 | 2A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3620 BONVIEW AVE

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-03

D. STREET ADDRESS (If rural, give location): 3620 BONVIEW AVE

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 4-17-1898

9. AGE (In years last birthday): 69

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): POLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? SNIADACH

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

16. (If yes, give war or dates of service)

SOCIAL SECURITY NO. 217-07-0835

17. INFORMANT: FRANCES FERRETTI

ADDRESS: 3620 BONVIEW AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Hypertension Art Sel. C-V Dis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/18 19 67 to 4/18 19 67, that (I) (we) last saw the deceased alive on DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. H. Goodman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/20/67

23C. PHYSICIAN'S NAME (Type): J. H. Goodman M.D.

23D. ADDRESS: 3700 E. Baltimore St Md

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-21-67

24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY

24D. LOCATION (City, town, or county) (State): BALTO MD

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Ralph E. Fogley M.D.

25C. FUNERAL DIRECTOR: JOHN M. WEBER & SONS INC.

ADDRESS: 401 S. CHESTER ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

B-255

BIRTH NO. 67 3925

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3925

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BAUGHMAN, RUBY M.

2. DATE AND HOUR OF DEATH: APRIL 19, 1967 | 11:35A.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 40 ST. AGNES HOSPITAL

((If not in hospitol or institution, give street oddress or locotion)

4. USUAL RESIDENCE (Where deceased lived. If institutian: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-06

D. STREET ADDRESS (If rurol, give locotion): 2805 SUNSET DRIVE 21223

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 5/16/1903

9. AGE (In years last birthday): 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J.HOWARD MARSHALL (DEC'D)

14. MOTHER'S MAIDEN NAME: PEARL BRUFF (DEC'D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NONE

(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 219-09-7185

17. INFORMANT: ST. AGNES HOSPITAL RECORDS

ADDRESS:

MEDICAL CERTIFICATION

1B. 540.01 - 260X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Anemia Anoxia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) GI Bleeding - — 4 Wks -

DUE TO

(C) Peptic Ulcer. — 3 Months -

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A.S.C.V.D. (Generalized) Diabetes Mellitus — + 5 Years.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 16 19 67 to APRIL 19 19 67, that (I) (we) last saw the deceased alive on APRIL 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 4/19/67

23C. PHYSICIAN'S NAME (Type): A. MEJIA M.D.

23D. ADDRESS: ST. AGNES HOSP; CATON & WILKENS AVES. 21229

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-22-1967

24C. NAME of CEMETERY or CREMATORY: Baltimore

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Ralph E. Farley M.D.

25C. FUNERAL DIRECTOR: G.Howard Strong

ADDRESS: 3207 W. North Ave.,

VS 150-REV. 1/1/65

3933

1
H-252

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH No. 67 3926 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 67 3926

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RAMOND HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD: April 18, 1967 4:55 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 35 Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 1934 E. Orleans Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): single
8. DATE OF BIRTH: Nov 11. 1934
9. AGE (In years last birthday): 32
If Under 1 Yr. Months: Days: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Leroy Hawkins
14. MOTHER'S MAIDEN NAME: Mattie Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leroy Hawkins ADDRESS: Same

MEDICAL CERTIFICATION

18. E 9369

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Left Subdural Hematoma
DUE TO
(B) Epilepsy
DUE TO
(C) Craniocerebral Injury.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Unknown 00-00
21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 15 (Year) '67 (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Unknown

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-22-67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1011 Bramble Pl

VS 151-REV. 1/1/65 NBS 4129 67 00 03934

49-04-78 IB

T-520 67 3927

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3927

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Annie Thomas M.

2. DATE AND HOUR OF DEATH: April 18, 1967 7:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 224 SILVER COURT #21202

5-01

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-6-91
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Scott
14. MOTHER'S MAIDEN NAME: Elizabeth Jackson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE
ADDRESS:

MEDICAL CERTIFICATION

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory Insufficiency — 3 days
DUE TO
(B) CVA — 1 mo
DUE TO
(C) ASCVD.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension,

19A. DATE OF OPERATION: 2.
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/10 1967 to 4/18 1967, that (I) (we) last saw the deceased alive on 4/18 1967 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Judith Hall M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): DR. JUDITH HALL M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE, BALTIMORE, MD 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-22-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Lloyd E. Jones
25C. FUNERAL DIRECTOR: Lloyd Wilson
ADDRESS: 1010 Brantley Ave

VS 150-REV. 1/1/65

3935

W-6 152

BIRTH NO. 67 3928

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3928

1. NAME OF DECEASED (Type or Print): Bernice Wernick

2. DATE AND HOUR OF DEATH: 17 April 67 | 4:05 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 17-03
D. STREET ADDRESS (If rural, give location): 711 N. Fremont Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	N	unknown	1-1-14	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknown	unknown	unknown Washington DC	USA

13. FATHER'S NAME: unknown Charles Stewart

14. MOTHER'S MAIDEN NAME: unknown Cathrine Soyer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Patient's chart — ADDRESS: Louise Robinson

MEDICAL CERTIFICATION

18. 331 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Intracerebral Hemorrhage — 5 Hrs.

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 14 April 19 67 to 3-4:05p-17 April 19 67, that (I) (we) last saw the deceased alive on 14 April 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John W. Eckholdt M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 17 April 67

23C. PHYSICIAN'S NAME (Type): John W. Eckholdt M.D.

23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-22-67	Western Star Cem	Catonsville Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967

25B. NAME OF REGISTRAR: Robert E. Lackey M.D.

25C. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantleyne

VS 150-REV. 1/1/65

1 9 6 7 0 0 0 3 9 3 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-20d

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3929 Registered No. 67 3929

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Joseph Wise — WISE

2. DATE AND HOUR OF DEATH: 4/19/67 12 30 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 10-02
D. STREET ADDRESS (If rural, give location): 814 CENTRAL AVENUE 21202

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: 12-8-97
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ARCH WISE
14. MOTHER'S MAIDEN NAME: ELLA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Virginia Lee — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 430.0 + 260 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular hemorrhage
DUE TO
(B) CVA
DUE TO
(C) ASCVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/19 1967, that (I) (we) last saw the deceased alive on 4/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth L. Brigham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): Kenneth C. Brigham M.D.
23D. ADDRESS: Johns Hopkins Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-24-67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: APR 20 1967
25B. NAME OF REGISTRAR: Robert E. Foley M.D.
25C. FUNERAL DIRECTOR: Elroy Batchelor — ADDRESS: 1001 Brantley Ave

VS 150-REV. 1/1/65

1
E-363

BIRTH NO. 67 3930

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3930

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PAULINE EDWARDS

2. DATE AND HOUR PRONOUNCED DEAD: April 16, 1967 3:58 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
33 99 Johns Hopkins Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 1744 E. North Avenue

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: April 23 1922
9. AGE (In years last birthday): 45
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manual Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levi Gerrar
14. MOTHER'S MAIDEN NAME: Jennie Cannon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Student Edwards
ADDRESS: Same

MEDICAL CERTIFICATION

1B. 490 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pneumonia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy [X] Partial and that on this basis, death in my opinion resulted from: Natural causes XX Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-20-67
23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem
23D. LOCATION (City, town, or county) (State): Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT. APR 20 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1020 Brooklyn Ave

VS 151-REV. 1/1/65

1967 0003938

1
P-620

BIRTH NO. 67 3931

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. X 67 3931

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY M. PRICE

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 3:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 31 Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 1922 Dunbury Drive

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: May 10, 1922
9. AGE (In years last birthday): [redacted] (44)
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Gephardt
14. MOTHER'S MAIDEN NAME: Agatha Bretzl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 218-09-2435
17. INFORMANT: Anna B. Jasek
ADDRESS: 3717 Hudson St. Balto. 24, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E812.7

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrocranial injuries
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 26-09 Eastern Avenue and Eaton Street

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 3-30-67 5:29 P.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by Baltimore Transit bus.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-21-67.
23C. NAME of CEMETERY or CREMATORY: St. Raymond's Cemetery
23D. LOCATION (City, town, or county) (State): Westchester, New York.

24A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Charles S. Zeiler
ADDRESS: 901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

N856.R967 0003931

K-152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3932 Registered No. 67 3932

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES JOSEPH KAVANAGH

2. DATE AND HOUR OF DEATH: April 16, 1967 | 5:00A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 520 Maude Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-04

D. STREET ADDRESS (If rural, give location): 520 Maude Ave.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	Jan. 31, 1888	79				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationery Engineer	Davision Chemical	Maryland	U.S.

13. FATHER'S NAME: John Patrick Kavanagh

14. MOTHER'S MAIDEN NAME: Ann Cummins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-03-9777

17. INFORMANT: Mrs. Catherine Kavanagh ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

002.1

(A) Tuberculosis, Pulmonary

DUE TO

(B) Bronchiectasis

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 15 1965 to 4/16 1967, that (I) (we) last saw the deceased alive on April 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Rubin M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: April 17, 1967

23C. PHYSICIAN'S NAME (Type): Samuel Rubin M.D.

23D. ADDRESS: 201 E. Patapsco Ave. Balto. Md. 21225

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	April 19, 1967	Holy Cross Cemetery	Ritchie Hwy. A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 21 1967	R. E. Fahrney	George J. Gonce	4001 Ritchie Hwy. (21225)

VS 150-REV. 1/1/65

1967 0003910

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-163 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3933 April Registered No. 67 3933

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MR. MILLER PAUL EVERETT

2. DATE AND HOUR OF DEATH: MARCH 17 1967 11 35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-09

D. STREET ADDRESS (If rural, give location): 1236 E. COLD SPRING LANE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 04-06-07

9. AGE (In years last birthday): 60

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker

10B. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): ~~Virginia~~ Oldtown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James WALTER MILLER

14. MOTHER'S MAIDEN NAME: CUSTER (Bertha Custer)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Claude Miller, Oldtown, Md. Brother

ADDRESS

MEDICAL CERTIFICATION

1B. 466 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Pulmonary edema of lungs

DUE TO

(B) Diabetes Mellitus

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral infarction
Myocardial infarction

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-16 19 67 to 4-17 19 67, that (I) (we) last saw the deceased alive on 4-17 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjof Fur Bjorn M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-17 67

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSON M.D.

23D. ADDRESS: Union Memorial Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Apr. 20, 1967

24C. NAME of CEMETERY or CREMATORY: Mt. Olive Cemetery

24D. LOCATION (City, town, or county) (State): Oldtown, Md. Allegany

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Talley M.D.

25C. FUNERAL DIRECTOR: James F. Scazzelli - Cumberland, Md

ADDRESS

VS 150-REV. 1/1/65

1 9 6 7 0 0 3 9 3 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-326

BIRTH NO. 67 3934

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3934

1. NAME OF DECEASED (Type or Print): Lorena Rudiger

2. DATE AND HOUR OF DEATH: 4/20/67 | 5:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University of Maryland Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 24-04

D. STREET ADDRESS (If rural, give location): 1823 Westphal pl.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12/23/06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ~~U.S.A~~ unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217 03 9011

17. INFORMANT: Mr. Charles E. Rudiger ADDRESS: 1823 Westphal Place

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/18 1967 to 4/20 1967, that (I) (we) last saw the deceased alive on 4:30 Am 4/20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Roosevelt Taylor, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/20/67

23C. PHYSICIAN'S NAME (Type): Roosevelt Taylor, Jr. M.D.

23D. ADDRESS: University of Maryland Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4 22 67

24C. NAME of CEMETERY or CREMATORY: Cedar Hill

24D. LOCATION (City, town, or county) (State): Brooklyn, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Roy E. Fahrney

25C. FUNERAL DIRECTOR: McCully ADDRESS: 130 E. Fort Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

G-516

BIRTH NO. 67 3935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3935

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ARTANAS, GANIPRAUSKI — Anthony, Ganipraushi

2. DATE AND HOUR OF DEATH: 4/18/67 — 5:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Midtown Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore — 11-02
D. STREET ADDRESS (If rural, give location): 808 St Paul St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 12/19/1888
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY: Clothing Co.
11. BIRTHPLACE (State or foreign country): Lithuania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-12-4023
17. INFORMANT: Mary Ann Jenkins — ADDRESS: 1010 W. Preston St. (23)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardio Respiratory Failure
DUE TO: Acute Myocardial Infarction
(B) Hypertensive - Art CVHD
DUE TO:
(C) Gen + Cerebral Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/13/63 19 to 4/18/67 19, that (I) (we) last saw the deceased alive on 4/18/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Willard Appelquist M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): WILLARD APPLEQUIST M.D.
23D. ADDRESS: 5507 Park Heights Av. Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/21/67
24C. NAME of CEMETERY or CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: John J. Cowan & Son Inc.
ADDRESS: 921 St. Hollins St. 23 Md.

VS 150-REV. 1/1/65

1967 0 3 4 3

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3936 Registered No. 67 3936

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FLINKMAN, ANNE MONTE

2. DATE AND HOUR OF DEATH: 4-16-67 11:38 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP. OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: U.S.A.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12-02

D. STREET ADDRESS (If rural, give location): 3501 ST. PAUL ST. 21218

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	WID.	8/27/06	60				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	BALTIMORE, MD.	U.S.A.

13. FATHER'S NAME: HARRY E. MADDOX

14. MOTHER'S MAIDEN NAME: [redacted] EDITH MAY BIDDISON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 207-12-9494

17. INFORMANT: MRS. JOHN F. [redacted], Tracy

ADDRESS: LUTHERVILLE, MD. 21093 BROADWAY RD.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Decerebration 2° to cerebral hypoxia — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs.

DUE TO

(B) Thrombosis, mitral commissurotomy

DUE TO

(C) Mitral Stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: Allan L. Smith M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 3 4/14/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: MITRAL STENOSIS

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 4-10- 1967 to 4-16 1967, that (I) (we) last saw the deceased alive on 4-16- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Prophet Pachan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/16/67

23C. PHYSICIAN'S NAME (Type): PROPHET PACHARN M.D.

23D. ADDRESS: SINAI Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/18/67

24C. NAME of CEMETERY or CREMATORY: HEBREW YOUNG MEN

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REST., RD.

Body released to Mr. Pate for cremation per Dr. Corrigan, Med. Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

G-637

67 3937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3937

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN GURWITZ

2. DATE AND HOUR OF DEATH: 4-17-67 5:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL 100 N. BROADWAY, BALTO

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-01

D. STREET ADDRESS (If rural, give location): 902 Chauncey Ave

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: April 19, 1920

9. AGE (In years last birthday): [redacted] 46

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~[illegible]~~ SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY: SHOES

11. BIRTHPLACE (State or foreign country): Baltimore, MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry SOL Gurwitz

14. MOTHER'S MAIDEN NAME: Kate Fisher

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-10-8227

17. INFORMANT: Norman Gurwitz

ADDRESS: 6316 Green Spring Ave

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) MYOCARDIAL INFARCTION

DUE TO

(B) CORONARY HEART DISEASE ?

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 HOURS

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-17- 1967 to 4-17 1967, that (I) (we) last saw the deceased alive on 4-17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rodelio M. Lim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-17-67

23C. PHYSICIAN'S NAME (Type): Rodelio M. Lim M.D.

23D. ADDRESS: Church Home & Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/18/67

24C. NAME of CEMETERY or CREMATORY: Mikro Kodesh Beth Israel

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Taylor

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reist. Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-62

BIRTH NO. 67 3938

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3938

1. NAME OF DECEASED (Type or Print): Meyers, Yetta (ETTA)

2. DATE AND HOUR OF DEATH: 4/18/67 1:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE, 24 6-02
D. STREET ADDRESS (If rural, give location): 415 N. MONTFORD AVENUE

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: [redacted]
9. AGE (In years last birthday): [redacted] 81
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): LITHUANIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JACOB KETRI
14. MOTHER'S MAIDEN NAME: FEIGA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-56-3941
17. INFORMANT: MRS. DORA SILVERSTEIN, 415 N. MONTFORD AVE. ADDRESS

MEDICAL CERTIFICATION

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Diabetes Mellitus — 18 yrs.
DUE TO
(B) ASCVD — 20 yrs.
DUE TO
(C) Bronchopneumonia — 2 wks.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/5 19 67 to 4/18 19 67, that (I) (we) last saw the deceased alive on 4/17/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C.H. Brown III M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): DR. C.H. BROWN 3RD M.D.
23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: BNAI ISRAEL, CONG.
24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS INC., 6010 REIST., RD. ADDRESS

VS 150-REV. 1/1/65

2033 85 RS MEYERS, YETTA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2570 3946

5-550

BIRTH NO. 67 3939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3939

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILTON M. SCHUMAN

2. DATE AND HOUR OF DEATH: 4/16/67 8:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore 42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-02
D. STREET ADDRESS (If rural, give location): 2611 Royal Oak Avenue #7

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: June 3, 1892
9. AGE (In years last birthday): 74
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Maurice Schuman
14. MOTHER'S MAIDEN NAME: Clara ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-09-4635A
17. INFORMANT: Mrs. Dorothy Schuman
ADDRESS: 2611 Royal Oak Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASCVD

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (~~I~~) (this hospital) attended the deceased from 4/14 1967 to 4/16 1967, that (I) (~~we~~) last saw the deceased alive on 4/16 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Abe Levy
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/16/67
23C. PHYSICIAN'S NAME (Type): ABE LEVY
M.D.
23D. ADDRESS: Sinai Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/18/67
24C. NAME of CEMETERY or CREMATORY: Chizuk Amuno (Arlington)
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.
ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

1967 00 3937

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3940 Registered No. 67 3940

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTHER MARY GOLDSTEIN

2. DATE AND HOUR OF DEATH: APRIL 18, 1967 8 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MT. SINAI NURSING HOME 4613 PARK HEIGHTS AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-18
D. STREET ADDRESS (If rural, give location): 4721 BEAUFORT AVENUE

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOW	JUNE 3, 1894	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	AT HOME	MANCHESTER, ENGLAND	USA

13. FATHER'S NAME: JOSEPH KERSHNER

14. MOTHER'S MAIDEN NAME: FANNY ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-10-1538 B

17. INFORMANT: MRS. DORIS LISSY, 4907 NELSON AVENUE #15

MEDICAL CERTIFICATION

18. I 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: (A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO: None

(B) DUE TO: None

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: None

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 1 1965 to April 18 1967, that (I) (~~we~~) last saw the deceased alive on April 18 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Manuel Levin M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/18/67

23C. PHYSICIAN'S NAME (Type): DR. MANUEL LEVIN M.D.

23D. ADDRESS: 4818 REISTERSTOWN ROAD

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4/19/67	HEBREW YOUNG MEN	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 21 1967	Robert E. Fahrney	SOL LEVINSON & BROS. INC.,	6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3941 Registered No. 67 3941

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PETERS MR. HARRY LEE

2. DATE AND HOUR OF DEATH: 4-19-1967 | 5.55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 CHURCH HOME & HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 3-01

D. STREET ADDRESS (If rural, give location): 1407 GOUGH ST. (31)

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWER

8. DATE OF BIRTH: 12/12/1902

9. AGE (In years last birthday): 64

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CRANE OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY: CANNERY

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? AMR.

13. FATHER'S NAME: JOHN PETERS

14. MOTHER'S MAIDEN NAME: ELLA BURME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 215-10-0611

17. INFORMANT: Mr Leo DWORKOWSKI ADDRESS: 1525 LOCUST ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Emphysema — many years

DUE TO Respiratory Failure

(B) A.S.C.V.D. — many years.

DUE TO No myocard. infarction

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3.28. 1967 to 4.19. 1967, that (I) (we) last saw the deceased alive on 4.19. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: K.M. Anandaiah M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/19/67

23C. PHYSICIAN'S NAME (Type): K.M. ANANDAIAH M.D.

23D. ADDRESS: Church Home & Hospital Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/22/67

24C. NAME of CEMETERY or CREMATORY: Glen Haven Memorial Park

24D. LOCATION (City, town, or county) (State): Ritchie Highway - Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Thomas J. Kenny Inc. ADDRESS: 1600 Holden St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-530

BIRTH NO. 67 3942

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3942

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CAREY MOHAMITT

2. DATE AND HOUR PRONOUNCED DEAD: April 5, 1967 4:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1021 Race Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-01
D. STREET ADDRESS (If rural, give location): 1021 Race Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH:
9. AGE (In years last birthday): 63
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. 1B. E983X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Manual Strangulation.

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hemoperitoneum due to Fractures of Liver.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1021 Race Street 23-01

21D. TIME OF INJURY (APPROX.) (Month) 4 (Day) 5 (Year) '67 (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Beaten and strangled.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4/6/67

23A. BURIAL CREMATION, REMOVAL (Specify):
23B. DATE: 4-17-67
23C. NAME of CEMETERY or CREMATORY:
23D. LOCATION (City, town, or county) (State):

24A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
24B. NAME OF REGISTRAR: Robert E. Falkenhan
24C. FUNERAL DIRECTOR: MORTUARY SERVICE - BCHD
ADDRESS:

VS 151-REV. 1/1/65

N991X 967 000 3950

1
M-260

BIRTH NO. 67 3943

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3943

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CLASSIE MAE McRAE

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 | 1:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 34 Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-02
D. STREET ADDRESS (If rural, give location): 5 N. Wheeler Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	SEPARATED	March 13-1943	24		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	At Home	Balto MD	U.S.A.

13. FATHER'S NAME: Preston Little

14. MOTHER'S MAIDEN NAME: Classie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Pauline W. Lee ADDRESS: 1313 Mulberry St

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E979X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Body Burns.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5 N. Wheeler Avenue 20-02

21D. TIME OF INJURY (APPROX.): (Month) 4 (Day) 16 (Year) '67 (Hour) P m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Set self afire.

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [X] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/21/67	Mt Auburn	Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 21 1967	Robert E. Farley, M.D.	Thomas Gwynn P. Hughes	638 N. Gilmor St

VS 151-REV. 1/1/65

N948.2 67 000395 1

J-232

BIRTH NO. 67 3944

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3944

1. NAME OF DECEASED (Type or Print): VIVIAN JUSTICE

2. DATE AND HOUR OF DEATH: 4-17-67 10:45A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
9-09
D. STREET ADDRESS (If rural, give location): 1841 Hope Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 7/19/28
9. AGE (In years last birthday): 38
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSES AIDE
10B. KIND OF BUSINESS OR INDUSTRY: CENTRAL SL. HOSP PETERSBURG VA
11. BIRTHPLACE (State or foreign country): PETERSBURG VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Abbey
14. MOTHER'S MAIDEN NAME: Lillian Coleman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: GRACE JACOBS SOUTH ALHAMBRA ALY
ADDRESS:

MEDICAL CERTIFICATION

18. 757.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) GRAM-NEGATIVE (E. coli) Septicemia 2° Infected Left cystic kidney — 3 WKS

(C) Renal insufficiency-etiology unknown — 8 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Respiratory paralysis — 8 days

19A. DATE OF OPERATION: 4-7-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Infected Left Kidney
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) attended the deceased from 4-7 1967 to 4-17 1967, that (I) last saw the deceased alive on 4-17 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.

23A. SIGNATURE: Joseph D. Schmidt M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-17-67
23C. PHYSICIAN'S NAME (Type): Joseph D. Schmidt M.D.
23D. ADDRESS: 601 N. BROADWAY BALTIMORE

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/20/67
24C. NAME of CEMETERY or CREMATORY: BLANDFORD
24D. LOCATION (City, town, or county) (State): PETERSBURG VA

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Bland Funeral Home
ADDRESS: Petersburg VA

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

114 10/02 JUSTICE, VIVIAN 5

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R-100

BIRTH NO. 67 3945

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3945

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DAVID B. ROBB

2. DATE AND HOUR PRONOUNCED DEAD: April 18, 1967 11:55 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-01
D. STREET ADDRESS (If rural, give location): 158 W. Cross Street

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 6-15-1898
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter
14. MOTHER'S MAIDEN NAME: Martha Robb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ollie Brown
ADDRESS: 104 Juniper Lan-Turner'S

MEDICAL CERTIFICATION

18. 422.1

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONset AND DEATH

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 4-19-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/21/67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Ct
23D. LOCATION (City, town, or county) (State): Balt City

24A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
24B. NAME OF REGISTRAR: [signature]
24C. FUNERAL DIRECTOR: Isaiah L Brown Jr
ADDRESS: 1082 Montgomery St.

VS 151-REV. 1/1/65

1967 0003953

1

M1-460

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3946 Registered No. 67 3946

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LOUISE ANNE MILLER

2. DATE AND HOUR PRONOUNCED DEAD: April 16, 1967 8:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2025 Guilford Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 515 East 21st Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 4/28/1929
9. AGE (In years last birthday): 37
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Howard
14. MOTHER'S MAIDEN NAME: Pauline Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Carolyn Bradford ADDRESS: 515 E 21 St

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 498 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: April 17, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-22-67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn
23D. LOCATION (City, town, or county) (State): Balto Ceby

24A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
24B. NAME OF REGISTRAR: Robert E. Falkenhan
24C. FUNERAL DIRECTOR: Isaac L Burn & Son ADDRESS: 108 W Montgomery St

VS 151-REV. 1/1/65

1967 0003954

M-263

67 3947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3947

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Evelyn Mae Kertie

2. DATE AND HOUR OF DEATH: 4-18-67 | 2:08 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 23-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230

D. STREET ADDRESS (If rural, give location): 1008 So. Hanover St.

5. SEX: F.

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 8-15-1916

9. AGE (In years last birthday): 50. | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: David Brooks

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: DOROTHY BROOKS ADDRESS: 146 W. HAMBURG ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 587.0+0.60X

(A) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) A. Pancreatitis, probably — 1 day

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ASCVDS, CHF — 15 years

Diabetes. Pneumonia — 20 years

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 12:0 mn 4/18 1967 to 2:08am 4/18 1967, that (we) last saw the deceased alive on 2:08am 4/18 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.

23A. SIGNATURE: Rifat Abousy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4-18-67

23C. PHYSICIAN'S NAME (Type): Rifat Abousy M.D.

23D. ADDRESS: SBGH

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/22/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Balto Md 1213 Light St Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Falkenna

25C. FUNERAL DIRECTOR: Isaiah L. Brown Sr. ADDRESS: 1981 Montgomery St

1967 0 0 0 3

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3948 Registered No. 67 3948

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SUMMERFIELD B. HENSON

2. DATE AND HOUR OF DEATH: April 19-1967 4 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 3803 Chatman Rd. Baltimore Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3803 Chatman Rd. CHATHAM

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): never married
8. DATE OF BIRTH: June 10-1880
9. AGE (In years last birthday): 87 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-03-422A
17. INFORMANT: Lillian Evans ADDRESS: Rep. Friend 3803 Chatman Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Card is Vascular Disease unknown DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 12 1963 to April 19 1967, that (I) (we) last saw the deceased alive on April 18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William H Watts M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4-20 67
23C. PHYSICIAN'S NAME (Type): William H Watts M.D.
23D. ADDRESS: 50 N Arlington Ave Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: April 24/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE RECEIVED HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: V. Brooks Ruggold ADDRESS: 1463 Lafayette St

VS 150-REV. 1/1/65 1 9 6 7 0 0 3 9 4 6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C.550 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3949 Registered No. 67 3949

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CAMMON, JOHN

2. DATE AND HOUR OF DEATH: APRIL 19 '67 | 6⁵⁰ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY of MARYLAND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: G.A.Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena 52-00

D. STREET ADDRESS (If rural, give location): Rt 8 Box 3

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 11-26-06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY: BeTh-Steel Co.

11. BIRTHPLACE (State or foreign country): Chester South Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BENJAMIN CAMMON

14. MOTHER'S MAIDEN NAME: IDA Sawyer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-09-4198

17. INFORMANT: Ulester Cammon ADDRESS: 2208 Montecello Rd

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory anoxia — Unknown

DUE TO

(B) Pulmonary metastases — Unknown

DUE TO

(C) Hypernephroma — Unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 18 1967 to April 19 1967, that (I) (we) last saw the deceased alive on April 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Timothy Kenney Gray M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-19-67

23C. PHYSICIAN'S NAME (Type): TIMOTHY KENNEY GRAY M.D.

23D. ADDRESS: UNIVERSITY of MARYLAND Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-22-67

24C. NAME of CEMETERY or CREMATORY: Carver Mem. Park

24D. LOCATION (City, town, or county) (State): LAUREL Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Morton & Dyett F.H. ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R 543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3950 Registered No. 67 3950

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOROTHY B. REYNOLDS

2. DATE AND HOUR OF DEATH: 16 APRIL '67 | 3:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: CITY 1901
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1633 EDMONSON AVE

5. SEX: F
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 4-20-28
9. AGE (In years last birthday): 39
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): Stevenson MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry A. Reynolds UNKNOWN 718-34-1997
14. MOTHER'S MAIDEN NAME: Mary Fitzhugh UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Helen Frazier ADDRESS: 1925 W. Fayette St

MEDICAL CERTIFICATION

1B. 332 XI

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Intraventricular Hemorrhage and Cerebral Infarct

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12 April 1967 to 16 April 1967, that (I) (we) last saw the deceased alive on 16 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 16 April '67
23C. PHYSICIAN'S NAME (Type): EMMANUEL M. MANIAGO M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): B
24B. DATE: Apr 22
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Thurley J. Cooper ADDRESS: 1212 N. Carrollton Ave
Joseph C. Burns 2222 W. Franklin

VS 150-REV. 1/1/65

67 0 0 0 3 9 5 0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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Y-520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3951 Registered No. 67 3951

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES R. YOUNG

2. DATE AND HOUR PRONOUNCED DEAD: 4-18-67 5:40 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1403
D. STREET ADDRESS (If rural, give location): 531 Prestman Street 21217

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: Aug. 30, 1925
9. AGE (In years last birthday): 41
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sylvester Young
14. MOTHER'S MAIDEN NAME: Emily Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-14-9555
17. INFORMANT: Emily T. Young ADDRESS: 1910 McCulloh St.

MEDICAL CERTIFICATION

18. 490X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 24
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Partial Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ Partial and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R S Fisher M.D.
EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 4-19-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4-22-67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Ave.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 9 5 9

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W-300

BIRTH NO. 67 3952

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3952

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAYNARD H. WHITE

2. DATE AND HOUR PRONOUNCED DEAD: April 18, 1967 10:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 5230 Denmore Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 5230 Denmore Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Single	March 8, 1935	32				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Drug Stroe	Baltimore, Maryland	U.S.A

13. FATHER'S NAME: Arthur O. White Sr

14. MOTHER'S MAIDEN NAME: Arcine Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	8/1957 - 3/23/59	218-32-8902	Mrs. Arcine White	5230 Denmore Ave

MEDICAL CERTIFICATION

1B. 420.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R S Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-19-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/22/67	St. Luke Cemetery	Reisterstown, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 21 1967	Roy E. Fulton	Herbert E. Nutter	3035 W. North Ave

VS 151-REV. 1/1/65

67 0 0 3 9 6 0

H-420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3953 Registered No. 67 3953

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOLSEY, Augustus Johnson

2. DATE AND HOUR OF DEATH: April 14, 1967 | 10:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd, Baltimore, Maryland 21218

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 301 Mc Mechen Street

14-01

5. SEX: Male
6. RACE: Nergo
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11-9-89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Letter Carrier
10B. KIND OF BUSINESS OR INDUSTRY: Post Office
11. BIRTHPLACE (State or foreign country): Athens, Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albon Holsey
14. MOTHER'S MAIDEN NAME: Sallie Thomas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 5/7/18 to 3/5/19
16. SOCIAL SECURITY NO.: 220-44-6461
17. INFORMANT: Records
ADDRESS: V.A. Hospital, Balto., Md. 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

260X

(A) UREMIA
DUE TO
(B) ARTERIOLAR NEPHROSCLEROSIS
DUE TO
(C) DIABETES MELLITUS

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 24 19 67 to April 14 19 67, that (I) (we) last saw the deceased alive on April 14, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David N. Marine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): DAVID N. MARINE, M.D.
23D. ADDRESS: Veterans Administration Hospital, 3900 Loch Raven Blvd. Baltimore, Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/19/67
24C. NAME of CEMETERY or CREMATORY: Baltimore, National Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Co. Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Falkenan
25C. FUNERAL DIRECTOR: Herbert E. Nutter
ADDRESS: 3035 W. North Ave.

VS 150-REV. 1/1/65

1967 0 3 9 6 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3954 Registered No. 67 3954

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): NED GRANT COPELAND.

2. DATE AND HOUR OF DEATH: 4/19/1967. 2.45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE. 15-04

D. STREET ADDRESS (If rural, give location): 2200 WALBROOK AVE. 21216

5. SEX: M

6. RACE: COL

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2/5/04.

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WAITER

10B. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: LEE COPELAND

14. MOTHER'S MAIDEN NAME: DELLA A. RICHARDSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 243-20-2690

17. INFORMANT: Mrs. Brightsy Copeland ADDRESS: 2200 Walbrook AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Aneurysm thoracic Aorta — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Bronchial Asthma

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Artery Aneurysm (Left)

19A. DATE OF OPERATION: NONE.

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Christopher J. Beetel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/19/67.

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS: M.D. UNIVERSITY HOSPITAL MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/24/67

24C. NAME of CEMETERY or CREMATORY: MOUNT AUBURN CEM.

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE RECD. BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Falkenham

25C. FUNERAL DIRECTOR: HERBERT E. NUTTER ADDRESS: 3035 W. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530

BIRTH NO. 67 3955

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3955

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILMA SMITH

2. DATE AND HOUR PRONOUNCED DEAD: 4-19-67 10:50 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 22 E. EAGER STREET - Amb. Crew #7

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

1102

D. STREET ADDRESS (If rural, give location): 22 E. Eager Street 21202

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Divorced	July 22, 1913	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher	Baltimore Public Schools	Lockport, N.Y.	U.S.A.

13. FATHER'S NAME: William H. Smith

14. MOTHER'S MAIDEN NAME: Louise Reese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-22-2000

17. INFORMANT: Mrs. Margaret Suchting

ADDRESS: R.D.1 Owings Mills, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R S Fisher M.D.

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-19-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4/22/67	Druid Ridge Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 21 1967	Robert E. Farley M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul St.

VS 151-REV. 1/1/65

1967 0 0 0 3 9 6 3

S-30 b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3956 Registered No. 67 3956

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDGAR ALLEN SWEET

2. DATE AND HOUR OF DEATH: April 20, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): ~~XXXX~~ 3210 N. Calvert St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	May 3, 1925	41 Years				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Self-employed	Wisconsin	U.S.A..

13. FATHER'S NAME: Sweet

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W.II.	390-12-2151	Mrs. Barbara Sweet	1303 N. Charles St.

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction — 1 hr

DUE TO

(B) Coronary insufficiency — 10 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 20 Sept 1962 to 20 April 1967, that (I) (we) last saw the deceased alive on 19 April 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James E. Rowe M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 21 April 67

23C. PHYSICIAN'S NAME (Type): James E. Rowe M.D.

23D. ADDRESS: 5550 Baltimore National Pike

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4/24/67	Baltimore National Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
APR 21 1967	Robert E. Fahey	Wm. Cook-Brooks, Inc.	1217 St. Paul St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3957 Registered No. 67 3957

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sarah May Dolan

2. DATE AND HOUR OF DEATH: 4/10/67 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3025 Windsor Ave Balt, Md

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 5631 Utrecht Rd.

5. SEX: F
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: May 26, 1893
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ellis Markell
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 212-36-2654
17. INFORMANT: Mrs. Ella Tober ADDRESS: 5631 Utrecht Road

MEDICAL CERTIFICATION

I — 1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: (A) Coronary Thrombosis

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/19/66 19 to 4/10/67 19, that (I) (we) last saw the deceased alive on 4/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/10/67
23C. PHYSICIAN'S NAME (Type): Harold Donahue M.D.
23D. ADDRESS: 930 Whitelock St Balt.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/14/67
24C. NAME of CEMETERY ~~or CREMATORY~~: Cedar Hill Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home Inc. ADDRESS: 1501 E. Fort Avenue

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-5610

West Virginia

BIRTH NO. 67 3958

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3958

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Robert L. Rummer Jr.

2. DATE AND HOUR OF DEATH: 4-17-67 | 8:55 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 93 The Children's Hospital Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. VA. B. COUNTY: Mineral
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Keyser, W. Va. V-45
D. STREET ADDRESS (If rural, give location): 47 Spring Street

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 5-22-65
9. AGE (In years last birthday): 1 yr.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert L. Rummer Sr.
14. MOTHER'S MAIDEN NAME: Janet Summers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Hospital Records
ADDRESS:

MEDICAL CERTIFICATION

18. 331 / X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Respiratory arrest — 20 min
DUE TO
(B) probable cerebral accident
DUE TO
(C) post arrest aspiration

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Meningomyelocele L1-S2 + hydrocephalus? Cerebellar atrophy

19A. DATE OF OPERATION: 2 mons
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour): Congenital
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/13 1967 to 4/17 1967, that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: E Dennis Lyne M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/17 67
23C. PHYSICIAN'S NAME (Type): E. DENNIS LYNE M.D.
23D. ADDRESS: CHILDREN'S HOSP, GREENSPRING AVE.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 4-19-67
24C. NAME of CEMETERY or CREMATORY: Queens Point Cemetery
24D. LOCATION (City, town, or county): Keyser (State): W. VA.

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Falkenna
25C. FUNERAL DIRECTOR: Harry W. Haight
ADDRESS: Sykesville, Md.

VS 150-REV. 1/1/65

C-5301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3959 Registered No. 67 3959

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CANNADAY GEORGE W

2. DATE AND HOUR OF DEATH: 4/17/67 2 00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: MARYLAND GEN'L HOSPITAL

10. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48

CERTIFICATE AMENDED 5-3-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: ~~Howard Co.~~ Carroll Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): SYKESVILLE MARYLAND 56-00
D. STREET ADDRESS (If rural, give location): 160 MANOR Rd

5. SEX: M
6. RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3-12-07
9. AGE (In years. If last birthday): 60 Sixty
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED GOVERNMENT
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): VA. —
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE T. CANNADAY
14. MOTHER'S MAIDEN NAME: MARY ACRES —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 212-24-8394
17. INFORMANT: Hospital Records
ADDRESS:

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia — 2 weeks
DUE TO
(B) ~~Cerebral Vascular accident~~ ~~2 months~~
DUE TO
(C) Anthesia and Positioning for ureteral Lithotomy.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ASCVD.

CERTIFICATION APPROVED BY: Charles J. Pelty, CHIEF ASST. MEDICAL EXAMINER 5-3-67

19A. DATE OF OPERATION: 2-17-67
19B. DISEASE FOR WHICH OPERATION WAS PERFORMED: Renal Calculus
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Maryland General Hospital
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 2/16/67 9:00 am
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR? Anoxia due to anesthesia + position necessary for operation.

22. I certify that ~~I~~ (this hospital) attended the deceased from 2-13-67 19 to 4-17-67 19, that ~~I~~ (we) last saw the deceased alive on 2-17-67 19 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~did not~~ view the body after death.

23A. SIGNATURE: Robert M Bezzley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 2/17/07
23C. PHYSICIAN'S NAME (Type): ROBERT M. BENZLEY M.D.
23D. ADDRESS: Maryland Gen'l Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-20-67
24C. NAME of CEMETERY or CREMATORY: LAKE View Memorial
24D. LOCATION (City, town, or county) (State): Sykesville, Md.

25A. DATE REC'D BY HEALTH DEPT. APR 21 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Luther H. Haight Sykesville, Md.
ADDRESS:

VS 150-REV. 1/1/65 N 9991 2 67 0003 2 67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 5-3-67 M.H.

W-256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3960 Registered No. 67 3960

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lucille Wagner

2. DATE AND HOUR OF DEATH: 4/18/67 10 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 1419 Edmondson Ave.

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/28/18
9. AGE (In years last birthday): 49
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): U.S.A. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alonzo White
14. MOTHER'S MAIDEN NAME: Jane —?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Self
ADDRESS: Same

MEDICAL CERTIFICATION

18. 420.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarct

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/14/67 19 to 4/18/67 19, that (I) (we) last saw the deceased alive on 4/18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert M Byers M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): Robert M. BYERS M.D.
23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/23/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967
25B. NAME OF REGISTRAR: Ralph E. Falkenstein
25C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

3968

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-400

BIRTH NO. 67 3961

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3961

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): David Lyle

2. DATE AND HOUR OF DEATH: April 20, 1967 7:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Bar Will Bar Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-09

D. STREET ADDRESS (If rural, give location): 3914 Bateman Ave

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 6/21/1876

9. AGE (In years last birthday): 90

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Samuel Lyle

14. MOTHER'S MAIDEN NAME: Winnie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 225-50-2633

17. INFORMANT: Mr. Harold Lyle ADDRESS: 3914 Bateman Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

491 X 4 E 90 4.8

(A) Hypostatic pneumonia

DUE TO

(B) Generalized debility

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fractured left hip and multiple abscesses in involved area

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY: Wilmer H. Ensor M.D. 4-27-67

19A. DATE OF OPERATION: 11-7-66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fracture of left hip

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☒ ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Home 3914 Bateman Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 10-29-66

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR? Deceased fell at home.

22. I certify that (I) (this hospital) attended the deceased from 12-14- 1966 to 4-19- 1967, that (I) (we) last saw the deceased alive on 4-19- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: C.R. Campbell M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/20/67

23C. PHYSICIAN'S NAME (Type): C.R. Campbell M.D.

23D. ADDRESS: 1618 W. North Ave - Balto, Md - 21217

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/24/67

24C. NAME of CEMETERY or CREMATORY: Family Lot

24D. LOCATION (City, town, or county) (State): Pamplin Prince Edward Co, Va

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: Herbert E. Nutter ADDRESS: 3035 W. North Ave

VS 150-REV. 1/1/65 N 820.10 3969

S-621

BIRTH NO. 67 3962

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3962

1. NAME OF DECEASED (Type or Print): Mary Sergovic

2. DATE AND HOUR OF DEATH: April 19, 1967 | 7:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 House in the Pines (Belair) Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01

D. STREET ADDRESS (If rural, give location): 3716 Greenmount Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 9/24/1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? ~~HORNIK~~ Hornik

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 154-26-7320

17. INFORMANT: John A. Sergovic

ADDRESS: 3 Edgewater Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infected multiple abdominal {incision / colostomy} — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

DUE TO

(B) correction of intestinal obstruction — 1 year

DUE TO

(C) retroperitoneal sarcoma — several years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Recurrent urinary tract infections — several years

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 2/6/ 1967 to 4/19 1967, that (I) (~~we~~) last saw the deceased alive on 4/11/1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Albert B Bradley M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/21/67

23C. PHYSICIAN'S NAME (Type): ALBERT BRADLEY M.D.

23D. ADDRESS: 4900 BELAIR ROAD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/24/67

24C. NAME of CEMETERY or CREMATORY: Mt. Olivet Cemetery

24D. LOCATION (City, town, or county) (State): Bloomfield New Jersey

25A. DATE REC'D BY HEALTH DEPT.: APR 21 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: John A. Morgan, Inc.

ADDRESS: 3000 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-506

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3963

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3963

1. NAME OF DECEASED (Type or Print): Edward M. ONEY

2. DATE AND HOUR OF DEATH: 4/21/67 | 11:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 13 N. Fulton Ave.

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 6/15/99
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Delaware — Seaford
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwary Oney
14. MOTHER'S MAIDEN NAME: Sarah Piatt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clara Cook — ADDRESS: 13 N Fulton Ave

MEDICAL CERTIFICATION

18. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebrovascular accident - Bleeding — 4 days
DUE TO
(B) Arteriosclerotic, hypertensive Cardio Vascular Ds — 10-20 yrs
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — Uraemia, Bronchopneumonia — 30 days

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? 1245

22. I certify that (this hospital) attended the deceased from 3/7/67 19 to 4/21/67 19, that (we) last saw the deceased alive on 4/21/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R Abouzy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/22/67
23C. PHYSICIAN'S NAME (Type): R Abouzy M.D.
23D. ADDRESS: 1213 Light Street Balto Md. 21230

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/26/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: Bowlus & Hughes 635 S. Conkling St
ADDRESS:

VS 150-REV. 1/1/65

M-006

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3964 Registered No. 67 3964

M.E. CASE NO. 34-64-63 C N

1. NAME OF DECEASED (Type or Print): GEORGE EDWARD MAYO

2. DATE AND HOUR OF DEATH: 20 April 67 | 2 42 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY OF MARYLAND HOSPITAL 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY: BALTO CITY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO 1603

D. STREET ADDRESS (If rural, give location): 1622 W. MOSHER ST.

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: 2/13/37

9. AGE (In years last birthday): 30 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10B. KIND OF BUSINESS OR INDUSTRY: FED. ADV. AGENCY

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: SAMUEL MAYO

14. MOTHER'S MAIDEN NAME: ANNIE Perry

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-34-2396

17. INFORMANT: Chart — ADDRESS:

CAUSE OF DEATH

MEDICAL CERTIFICATION

I — 1B. 340.1 + 581.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNUEMOCOCCAL MENINGITIS — INTERVAL BETWEEN ONSET AND DEATH: Approx 48 Hrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ALCOHOLIC CIRRHOSIS — Approx 5 years

19A. DATE OF OPERATION: 19 Apr 67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Resp. Insuff

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 Apr 1967 to 20 Apr 1967, that (I) (we) last saw the deceased alive on 20 Apr 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Music M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 20 Apr 67

23C. PHYSICIAN'S NAME (Type): STANLEY MUSIC M.D.

23D. ADDRESS: C/o Univ. of Md. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/24/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Fortune

25C. FUNERAL DIRECTOR: Marion P. Hayes — ADDRESS: 638 N Gilmor St

VS 150-REV. 1/1/65

T-240

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 3965

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3965

1. NAME OF DECEASED (Type or Print): MILDRED H. TISZL

2. DATE AND HOUR OF DEATH: 4-23/67 10 15 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 6231 GELSTON PARK RD.

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 3-24-20

9. AGE (In years last birthday): 47

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bosies

14. MOTHER'S MAIDEN NAME: MARGARET DIETZ

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 213-18-7987

17. INFORMANT: Joseph TISZL

ADDRESS: 6231 Gelston Park Road.

MEDICAL CERTIFICATION

18. 288 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary embolism — minutes

DUE TO

(B) HEART FAILURE — 2 days

DUE TO

(C) GOUT ARTHRITIS — 20 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 20 1967 to April 23 1967, that (I) (we) last saw the deceased alive on April 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fernando Q M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-23/67

23C. PHYSICIAN'S NAME (Type): FERNANDO QUERAL M.D.

23D. ADDRESS: LUTHERAN HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-26-67

24C. NAME of CEMETERY or CREMATORY: NEW CATHEDRAL

24D. LOCATION (City, town, or county) (State): BALTIMORE, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Ralph E. Farley M.D.

25C. FUNERAL DIRECTOR: GEO. L. SCHWAB FUNERAL HOME

ADDRESS: Hospital Miller 2101 Frederick Ave.

VS 150-REV. 1/1/65

48-47-12 DH

T-524 67 3366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3366

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Tinsley (James Tinsley)

2. DATE AND HOUR OF DEATH: 4-22-67 1940 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1633 Hakesley Place #21213

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 6-6-00

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel Shipyard

11. BIRTHPLACE (State or foreign country): Va. (Virginia)

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Rubin

14. MOTHER'S MAIDEN NAME: Hazel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 236-10-2202

17. INFORMANT: BCH RECORDS

ADDRESS: 4940 Eastern Avenue Baltimore, Md. #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: July 1965 (20 mos)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: July 1965 JH.H.

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Larynx

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): None

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jun 4-20-1967 to Present 4-22 1967, that (I) (we) last saw the deceased alive on April 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles B. Beckman M.D. — Attending Phys. ☐ Med. Director ☐ Stoll Phys. ☒

23B. DATE SIGNED: 4-22-67

23C. PHYSICIAN'S NAME (Type): Charles B. Beckman M.D.

23D. ADDRESS: 4940 Eastern Avenue Baltimore, Md. Balt. City Hospitals #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 27/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park

24D. LOCATION (City, town, or county) (State): Arbutus Md

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert G. [illegible]

25C. FUNERAL DIRECTOR: Milton E. Elickson

ADDRESS: 1129 N Carlton St

VS 150-REV. 1/1/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
S-530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 3967 Registered No. 67 3967

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM E. SMITH

2. DATE AND HOUR PRONOUNCED DEAD: April 19, 1967 6:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 516 Aisquith Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore S-02
D. STREET ADDRESS (If rural, give location): 516 Aisquith Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower
8. DATE OF BIRTH: Sept 4, 1901
9. AGE (In years last birthday): 65
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Smith
14. MOTHER'S MAIDEN NAME: Ida Bundy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ida Malone ADDRESS: 107 Albemarle St

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/20/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: April 22/67
23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem
23D. LOCATION (City, town, or county) (State): A. A. County Md

24A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
24B. NAME OF REGISTRAR: Robert E. Farber M.D.
24C. FUNERAL DIRECTOR: Grant T. Elliker ADDRESS: 1129 N. Carlton St

VS 151-REV. 1/1/65

1967 0003975

5-537

BIRTH NO. 67 3968

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3968

1. NAME OF DECEASED (Type or Print): ETTA SNOWDEN

2. DATE AND HOUR OF DEATH: 4/22/67 | 2:33 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3510 W. Lexington ST. Balto., Md. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: same B. COUNTY: Md. 20-07

C. CITY OR TOWN (If outside city limits, write RURAL and give township): same Baltimore

D. STREET ADDRESS (If rural, give location): same 3510 W. LEXINGTON

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 10/9/98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COOK

10B. KIND OF BUSINESS OR INDUSTRY: Private home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Carey

14. MOTHER'S MAIDEN NAME: Josephine Wanser (?)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-10-9881

17. INFORMANT: Husband ADDRESS: same

MEDICAL CERTIFICATION

1B. 181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Chr. Myelocytic Leukemia — 6 months

DUE TO

and Carcinoma of Bladder — 1 1/2 yrs.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 3/18 1967 to Present, that (I) (~~we~~) last saw the deceased alive on 4/18 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: D. W. Stewart M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4/22/67

23C. PHYSICIAN'S NAME (Type): D. W. STEWART M.D.

23D. ADDRESS: 3414 DUVALL AV. BALTO., MD. 21216

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/24/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park

24D. LOCATION (City, town, or county) (State): Arbutus Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Fallon

25C. FUNERAL DIRECTOR: Noah T. Eubanks

ADDRESS: 1129 N. Carolina St

VS 150-REV. 1/1/65

1967 0 0 3 9 6 8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-05-62 T1630 67 3969
EGL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 49 05 62

Registered No. 67 3969

1. NAME OF DECEASED (Type or Print): Eben Truitt

2. DATE AND HOUR OF DEATH: 4/19/67 | 8:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: WORCESTER 6
C. CITY OR TOWN (If outside city limits, write RURAL and give township): SNOW HILL 73-00
D. STREET ADDRESS (If rural, give location): ROUTE #1

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 8-31-89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: LEVIN
14. MOTHER'S MAIDEN NAME: MAGGIE ARMSTRONG

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-16-8889
17. INFORMANT: BCH: RECORDS 4940 EASTERN AVENUE
ADDRESS

MEDICAL CERTIFICATION

18. 204.31
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH: (A) Acute Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Uric Acid nephropathy — 4 days

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/11/67 19 to 4/19 19 67, that (I) (we) last saw the deceased alive on 4/19/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lee J. Silver M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/19/67
23C. PHYSICIAN'S NAME (Type): Lee J. Silver M.D.
23D. ADDRESS: Baltimore City Hospital, Baltimore Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/22/67
24C. NAME of CEMETERY or CREMATORY: Ebenezer Meth. Cem.
24D. LOCATION (City, town, or county) (State): Snow Hill Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Tagley M.D.
25C. FUNERAL DIRECTOR: Danny Lawson
ADDRESS: Princess Anne, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-12-0

BIRTH NO. 67 3970

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3970

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BURGEE, HORACE F.

2. DATE AND HOUR OF DEATH: 19 Apr 67 1 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD B. COUNTRY: USA Balt. C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 617 Hillen Rd

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 04-08-92
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FUNERAL DIRECTOR
10B. KIND OF BUSINESS OR INDUSTRY: Funeral Service
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HORACE BURGEE
14. MOTHER'S MAIDEN NAME: LIDA A FOSTER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No
(If yes, give war or dates of service):
SOCIAL SECURITY NO. 220-34-7359
17. INFORMANT: HORACE F BURGEE JR ADDRESS: 3631 Falls Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 560.4

(A) PNEUMONIA
DUE TO
(B)
DUE TO
(C) Peptic Esophagitis & Hiatus Hernia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4-14-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hiatus Hernia
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 3-16-67 19 to 4-19-67 19, that (I) ~~(we)~~ last saw the deceased alive on 4-18 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: M.B. Flynn M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-19-67
23C. PHYSICIAN'S NAME (Type): M. B. Flynn M.D.
23D. ADDRESS: Maryland General Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-22-67
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cem
24D. LOCATION (City, town, or county) (State): Pikesville Md

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Ralph E. Fahrney M.D.
25C. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 21211 3631 Falls Rd
By Horace F. Burgee Jr

VS 150-REV. 1/1/65

m-100

67-07719

BIRTH NO. 67 3971

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3971

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ~~BABY GIRL~~ LISA Ann MEHAFFIE

2. DATE AND HOUR OF DEATH: 4-22-67 | 3:38 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTIMORE~~ Owings Mills, 53-00
D. STREET ADDRESS (If rural, give location): 126 PLEASANT HILL Rd. ~~OWINGS MILLS~~

5. SEX: F
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): N.M.
8. DATE OF BIRTH: 4-21-67
9. AGE (In years last birthday): If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: 5 | Min.: 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): USA - MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM LAWRENCE MEHAFFIE
14. MOTHER'S MAIDEN NAME: CAROL JOANNE TARTAR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hosp. chart
ADDRESS:

MEDICAL CERTIFICATION

1B. 776X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PREMATURITY
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: 0 —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4-21 1967 to 4-22 1967, that (I) (we) last saw the deceased alive on 4-22 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Judith D. Gardner M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-22-67
23C. PHYSICIAN'S NAME (Type): DR JUDITH D GARDNER M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-24-67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: H. J. ECKHARDT
ADDRESS: Owings Mills, Md.

VS 150-REV. 1/1/65

1967 0 0 3 9 7 2

H-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3972 Registered No. 67 3972

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MAGGIE Ophelia HARRIS

2. DATE AND HOUR OF DEATH: 4-19-67 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2110 Bolton Street Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-02
D. STREET ADDRESS (If rural, give location): 2110 Bolton Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	Colored	married	7-26-98	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printer	Printing	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Amos Jones

14. MOTHER'S MAIDEN NAME: Mary Keys

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-16-8463A

17. INFORMANT: William O. Harris ADDRESS: 2110 Bolton St. 21217

MEDICAL CERTIFICATION

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertensive Cardio-Vascular Lesion — 1 year

DUE TO

(B) Stroke

~~DUE TO~~

(C) Cerebro Vascular Accident — 1 year

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1967 to 4-19 1967, that (I) (~~we~~) ~~last saw~~ the deceased alive on Apr 1 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Simon H. Carter M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 20 Apr 67

23C. PHYSICIAN'S NAME (Type): Simon H. Carter M.D.

23D. ADDRESS: 4215 Park Heights Ave

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	4-22-67	Mt. Auburn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Marshall W. Jones, Jr. ADDRESS: 1735 Harford Ave.

3980

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-36B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3973 Registered No. 67 3973

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VIRGINIA MUTHERT

2. DATE AND HOUR OF DEATH: 4/22/1967 11:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTO GENERAL

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTO. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): TOWSON 21204
D. STREET ADDRESS (If rural, give location): 502 CLUB LANE 53-00

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 5/14/1908
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALES WOMAN
10B. KIND OF BUSINESS OR INDUSTRY: DEPT. STORE
11. BIRTHPLACE (State or foreign country): U.S.A. - OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK MUTHERT
14. MOTHER'S MAIDEN NAME: MINNIE MAE PETERSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 290-05-2096
17. INFORMANT: Mrs. MARISSA M. THRASHER ADDRESS: 502 CLUB LANE 21204

MEDICAL CERTIFICATION

1B. 416X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL EMOBULUS — 10 days
DUE TO
(B) Rheumatic Heart Disease — 10 years
DUE TO
(C) ~~DUE~~

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUODENAL ULCER, BLEEDING — 7 days

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 1960 to April 23, 1967, that (I) (~~we~~) last saw the deceased alive on 4/22/1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert T. Parker M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 4/23/1967
23C. PHYSICIAN'S NAME (Type): ROBERT T. PARKER M.D.
23D. ADDRESS: SOUTH BALTO GEN. HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/26/67
24C. NAME of CEMETERY or CREMATORY: Oak Hill Cemetery
24D. LOCATION (City, town, or county) (State): Glendale, Ohio.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson ADDRESS: 1050 York Rd. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-00-39TN 1 E-210

BIRTH NO. 67 3974

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3974

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Eckhoff Mary

2. DATE AND HOUR OF DEATH: 4-23-67 / 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 11-01

D. STREET ADDRESS (If rural, give location): 1001 ST. PAUL ST. 21202

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 10-18-88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PAINTER D. WEST

14. MOTHER'S MAIDEN NAME: ELISE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-22-9575

17. INFORMANT: BCH: RECORDS

ADDRESS: 4940 EASTERN AVENUE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Diabetes Mellitus — 20 + yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 4-3 1967 to 4-23 1967, that (I) ~~(we)~~ last saw the deceased alive on 4-23 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: A P Weinfield M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-23-67

23C. PHYSICIAN'S NAME (Type): DR. A. P. WEINFIELD M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE BALTO. MD. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4/26/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: R. E. Fackenthal

25C. FUNERAL DIRECTOR: Wm Cook-Brooks Inc.

ADDRESS: 1217 St Paul & Preston

VS 150-REV. 1/1/65

3 0 8 2

N-425

BIRTH NO. 67 3975

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3975

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Kathryn B. Nelson

2. DATE AND HOUR OF DEATH: 4-21-67 | 3:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Keswick Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 700 W. 40th Street

13-07

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 12-17-91
9. AGE (In years last birthday): 75
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Montour Falls, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nicholas Bauer
14. MOTHER'S MAIDEN NAME: Otilda Mueller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Keswick Records
ADDRESS:

MEDICAL CERTIFICATION

18. 443 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertensive Cardiovascular Disease — 6 yrs
DUE TO
(B) Cerebrovascular Accident — 6 yrs
DUE TO
(C) Cerebrovascular Accident — 2 wks

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6 Jan 1964 to 21 Apr 1967, that (I) (we) last saw the deceased alive on 21 Apr 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Aubrey D. Richardson M.D. Attending Phys. ☐ Med. Director ☑ Staff Phys. ☐
23B. DATE SIGNED: 4-21-67
23C. PHYSICIAN'S NAME (Type): Aubrey D. Richardson, M.D.
23D. ADDRESS: 700 W. 40th Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-24-67
24C. NAME of CEMETERY or CREMATORY: Oakwood
24D. LOCATION (City, town, or county) (State): Syracuse, N.Y.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, Towson, Md. 21204
ADDRESS:

VS 150-REV. 1/1/65

K-406

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3976 Registered No. 67 3976

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Helen May Kahl

2. DATE AND HOUR OF DEATH: 17 Apr 1967 | 1:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 Keswick - employee

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-07
D. STREET ADDRESS (If rural, give location): 700 W. 40th Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	6-1-06	60		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Occ. Therapy Assistant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Waynesburro, Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dyson Palmer
14. MOTHER'S MAIDEN NAME: Elizabeth Hickman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 212-22-2122
17. INFORMANT: Keswick Personnel Records
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 148X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Myocardial Infarction — None
DUE TO
(B) Carcinoma left pharynx — 18 months
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on 17 Apr 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Aubrey D. Richardson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 17 Apr 1967
23C. PHYSICIAN'S NAME (Type): Aubrey D. Richardson M.D.
23D. ADDRESS: 700 W. 40th Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/21/67
24C. NAME of CEMETERY or CREMATORY: National
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Paul F. Chenowith
ADDRESS: 3417 Chestnut Ave.

VS 150-REV. 1/1/65

D-506

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3977 Registered No. 67 3977

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN C. DEAN

2. DATE AND HOUR OF DEATH: 4-19-67 | 1:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 9-04
D. STREET ADDRESS (If rural, give location): 727 EXETER HALL AVE

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 9-21-25
9. AGE (In years last birthday): 41
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY: G.E.M.
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: CHART
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 260 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INFARCT — HRS.

DUE TO

(B) ARTERIOSCLER. CARDIOVASC. DIS. — YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS — YEARS

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4-19 19 67 to 4-19 19 67, that (I) ~~(we)~~ last saw the deceased alive on 4/19 19 67 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Frank Caruzzi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4-19-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/24/67
24C. NAME of CEMETERY or CREMATORY: National
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE RECD BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: Paul E. Chenowetz
ADDRESS: 2617 Chestnut Ave.

VS 150-REV. 1/1/65

9 6 7 0 3 9 7 7

1
W-326

BIRTH NO. 67 3978

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3978

1. NAME OF DECEASED (Type or Print): MILDRED B. WHITAKER

2. DATE AND HOUR PRONOUNCED DEAD: April 20, 1967 | 5:02 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 4200 Maryland Place

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	10-15-1902	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Saleslady & Buyer	Hess Shoe Company	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Louis W. Schroeder

14. MOTHER'S MAIDEN NAME: Hattie Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-26-7360

17. INFORMANT: Mr. Earle L. Whitaker, Jr. ADDRESS: 4200 Maryland Place Balto., Md. 21229

MEDICAL CERTIFICATION

18. 193.0

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain Tumor (Ependymoma).

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Charles S. Petty M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 5/25/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-24-1967	Mt. Olivet Cemetery	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 24 1967	Robert E. Barber, M.D.	Howard H. Hubbard	4107 Wilkens Ave. 21229

VS 151-REV. 1/1/65

1967 0 0 3 9 8 6

H-45B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3979 Registered No. 67 3979

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOLLAND, CATHERINE JANET

2. DATE AND HOUR OF DEATH: APRIL 19, 1967 | 3:45AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD.

40

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21225 25-04

D. STREET ADDRESS (If rural, give location): 3437 SIXTH ST.

5. SEX: FEMALE

6. RACE: CAUCASION

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 01-26-~~1~~ 22

9. AGE (In years last birthday): 45

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT SCHUMACHER

14. MOTHER'S MAIDEN NAME: GRACE TRACEY DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNKNOWN

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST. AGNES RECORDS; WILKENS & CATON AVES.

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

416X

(A) Rheumatic Heart Disease

DUE TO

(B) Cardiac Cirrhosis

DUE TO

(C) Cardiac failure.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from APRIL 7 19 67 to APRIL 19 19 67, that (I) (we) last saw the deceased alive on APRIL 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. George Angov M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4-19-67

23C. PHYSICIAN'S NAME (Type): GEORGE ANGOV, M.D.

23D. ADDRESS: WILKENS & CATON AVES. BALTO. 29, MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: April 22, 1967

24C. NAME of CEMETERY or CREMATORY: Glen Haven Mem. Pk.

24D. LOCATION (City, town, or county) (State): Glen Burnie, A. A. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: George J. Gonce

ADDRESS: 4001 Ritchie Hwy. (21225)

VS 150-REV. 1/1/65

67 0 3 9 8 7

M-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3980 Registered No. 67 3980

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FREDERICK CHARLES MAISEL

2. DATE AND HOUR OF DEATH: APRIL 22, 1967 | 3:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: ZONE 21228 Balto Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 507 VALCOUR ROAD

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 12-23-~~89~~
9. AGE (In years last birthday): ~~76~~ 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PROF. BASBALL
10B. KIND OF BUSINESS OR INDUSTRY: BALTO. ORIOLES BASEBALL TEAM
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHRISTIAN MAISEL
14. MOTHER'S MAIDEN NAME: ELEANOR DILL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): -----
16. SOCIAL SECURITY NO.: 217-34-8954
17. INFORMANT: ST. AGNES HOSPITAL, WILKENS & CATON AVE. ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 177X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Circulatory Collapse

DUE TO

(B) Septic shock — 2 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of the prostate -

19A. DATE OF OPERATION: 4-17-67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Prostate -
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from MARCH 25 1967 to APRIL 22 1967, that (I) (we) last saw the deceased alive on APRIL 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alexander Mejia M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: APRIL 22, 1967
23C. PHYSICIAN'S NAME (Type): DR. ALEX MEJIA M.D.
23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE

24A. BURIAL CREMATION, REMOVAL (Specify): ENTOMBMENT
24B. DATE: 4/25/67
24C. NAME of CEMETERY or CREMATORY: LORRAINE
24D. LOCATION (City, town, or county) (State): BALTO. CO. MD

25A. DATE RECEIVED BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: E.S. MALNABB ADDRESS: 301 FREDERICK RD 21228

VS 150-REV. 1/1/65

1967 0003980

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-320

121 72 0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3981 Registered No. 67 3981

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Matthews, John W.

2. DATE AND HOUR OF DEATH: 4-17-67 9:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Worcester Co. ~~Worchester~~

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pocomoke City 73-42

D. STREET ADDRESS (If rural, give location): 708 Clarke Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9/2/14

9. AGE (In years last birthday): 52

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trainer

10B. KIND OF BUSINESS OR INDUSTRY: Horses

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Matthews

14. MOTHER'S MAIDEN NAME: Minnie Powell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: unk

17. INFORMANT: Mrs Claire Matthews, ADDRESS: 708 Clarke Ave. Pocomoke City, Md.

MEDICAL CERTIFICATION

1B. 146X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Metastatic CA

DUE TO

(B) nasopharyngeal CA

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/12 1967 to 4/17 1967, that (I) (we) last saw the deceased alive on 4/17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Monica M Buckley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 4/17/67

23C. PHYSICIAN'S NAME (Type): Monica M. Buckley M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-20-1967

24C. NAME of CEMETERY or CREMATORY: First Baptist

24D. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Fauber

25C. FUNERAL DIRECTOR: Robert H. Watson

ADDRESS: Pocomoke City, Md.

Robert H. Watson

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3982 Registered No. 67 3982

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SOBOLEFF, SARAH Joanah

2. DATE AND HOUR OF DEATH: 4/18/67 8:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION: MARYLAND GENERAL HOSPITAL (If not in hospital or institution, give street address or location)

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 11-03
D. STREET ADDRESS (If rural, give location): 306 W FRANKLIN ST.

5. SEX: F
6. RACE: Canc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~XXXXXXXX~~ WIDOW
8. DATE OF BIRTH: 04/12/~~82~~ 1879
9. AGE (In years last birthday): ~~85~~ 88
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): ? MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ? ROBERT McKENSY WISE
14. MOTHER'S MAIDEN NAME: LYDIA A Biscoe

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: GROVER WISE ADDRESS: THREE NOTHC ROAD LEXINGTON PK., MARYLAND

MEDICAL CERTIFICATION

18. 541.1 I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PERITONITIS — 4 DAYS.
DUE TO
(B) PERFORATED DUODENAL ULCER — 4 DAYS
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 4/17/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: PERITONITIS 2° DUODENAL ULCER
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4-17-67 19 to 4-18-67 19, that ~~I~~ (we) last saw the deceased alive on 4-18-67 19 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert M Brazley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 4/18/67
23C. PHYSICIAN'S NAME (Type): ROBERT M. BEAZLEY M.D.
23D. ADDRESS: MARYLAND GEN'L HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: APRIL 21, 1967
24C. NAME of CEMETERY or CREMATORY: ST ANDREWS
24D. LOCATION (City, town, or county) (State): LEONARDTOWN, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: R. Lee E. Faulkner
25C. FUNERAL DIRECTOR: W. Clarke Mattingley ADDRESS: Leonardtown, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3983 Registered No. 67 3983

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Moses Raskin M.D.

2. DATE AND HOUR OF DEATH: 4/19/67 2:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20

D. STREET ADDRESS (If rural, give location): 6221 Greenspring Ave

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9/15/91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHYSICIAN

10B. KIND OF BUSINESS OR INDUSTRY: EYE, EAR, NOSE & THROAT

11. BIRTHPLACE (State or foreign country): SAVANNAH, GEORGIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Solomon Raskin

14. MOTHER'S MAIDEN NAME: Sarah ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES

(If yes, give war or dates of service): W.W. 1 ARMY

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: DR. JOAN RASKIN, 6221 GREENSPRING AVENUE

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Hypotension — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs

DUE TO

(B) Pseudomonas septicemia

DUE TO

(C) Acute Myocardial infarction c̄ CHF

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Prostatitis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/15 1967 to 4/19 1967, that (I) (we) last saw the deceased alive on 4/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William A. Scovill M.D.

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-19-67

23C. PHYSICIAN'S NAME (Type): William A. Scovill M.D.

23D. ADDRESS: University of Maryland Hospital Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4/19/67

24C. NAME of CEMETERY or CREMATORY: BON AVENTURE

24D. LOCATION (City, town, or county) (State): SAVANNAH, GEORGIA

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: R. Ogden Faburn

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., 6010 REIST. RD.

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-600

BIRTH NO. 67 3984

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3984

1. NAME OF DECEASED (Type or Print): SCHER, HERMAN

2. DATE AND HOUR OF DEATH: 4/19/67 12:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALT

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 28-41
D. STREET ADDRESS (If rural, give location): 5602 BURTIS AVE #7

42

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	MARRIED	8/12/01	65				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN	CLOTHING	RUSSIA	USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-05-7060A

17. INFORMANT: MRS. SYLVIA SCHER, ADDRESS: 5602 BURTIS AVENUE #7

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

200.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RETICULUM CELL SARCOMA — 6 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/24 1967 to 4/19 1967, that (I) (we) last saw the deceased alive on 4/18 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David A. Spott M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/19/67

23C. PHYSICIAN'S NAME (Type): D.A. SPOTT M.D.

23D. ADDRESS: SINAI HOSP OF BALT

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	4/20/67	SHAAREI TFILOH	BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Fraley M.D.

25C. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC., ADDRESS: 6010 REIST., RD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-26b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3985 Registered No. 67 3985

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE L. McCORKLE

2. DATE AND HOUR OF DEATH: 4/19/67 915 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND: MARYLAND GEN'L HOSPITAL

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Harford, 62-00
C. CITY OR TOWN (If outside city limits, write RURAL and give township): FALLSTON MARYLAND 21047
D. STREET ADDRESS (If rural, give location): RT #1 - BOX 457 WATERS ~~ROAD~~ AVE

5. SEX: MALE

6. RACE: WHITE CAUC.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10-29-96

9. AGE (In years last birthday): 70

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY: RETIRED - CONSTRUCTION

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM McCORKLE

14. MOTHER'S MAIDEN NAME: LAURA GRICE ~~UNKNOWN~~

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 216-10-2144

17. INFORMANT: FAMILY ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — 10 days -

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) ASCVD - Arteriosclerotic Cardiovascular Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic lung disease -

19A. DATE OF OPERATION: 10 April 67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: abdominal aneurysm

20A. AUTOPSY (Yes or No): Y

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 3-25-67 19 to 4-19-67 19, that ~~I~~ (we) last saw the deceased alive on 4-19-67 19 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert M Beazley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 4/19/67

23C. PHYSICIAN'S NAME (Type): ROBERT M BEAZLEY M.D.

23D. ADDRESS: Maryland Genl Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 4-22-67

24C. NAME of CEMETERY ~~or CREMATORY~~: BEL AIR MEMORIAL GARDENS

24D. LOCATION (City, town, or county) (State): BEL AIR HARFORD CO. MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Fankhauser

25C. FUNERAL DIRECTOR: J. Walter Conklin ADDRESS: 5444 BELAIR Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3986 Registered No. 67 3986

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mabel Bordelia Nunallie

2. DATE AND HOUR OF DEATH: 4/19/67 10:35 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: Balt City C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt 18-01 D. STREET ADDRESS (If rural, give location): 884 W Baltimore St.

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 8. DATE OF BIRTH: 11/17/08 9. AGE (In years last birthday): 58 If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home 10B. KIND OF BUSINESS OR INDUSTRY: Home Wife 11. BIRTHPLACE (State or foreign country): Va. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Emmett Putnam 14. MOTHER'S MAIDEN NAME: Nora ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: Mrs Helen Parris ADDRESS: 313 Sunset Drive, Glenburnie, Md.

MEDICAL CERTIFICATION

1B. 420.1 I

CAUSE OF DEATH — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO (B)

DUE TO (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/3/67 1967 to 4/19 1967, that (I) (we) last saw the deceased alive on 4/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James Arnold M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 4/19/67

23C. PHYSICIAN'S NAME (Type): James Arnold M.D. 23D. ADDRESS: Box 138 University Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 4/22/67 24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967 25B. NAME OF REGISTRAR: Robert E. Farley M.D. 25C. FUNERAL DIRECTOR: John J. Cogan & Son Inc. ADDRESS: 901 Hollins St. Balto. Md. 23

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

49-10-82
FR

U-320

BIRTH NO. 67 3987

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3987

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Albert Whitehouse

2. DATE AND HOUR OF DEATH: 4/20/67 | 8 15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00 RURAL Essex
D. STREET ADDRESS (If rural, give location): 810 Woodrow Avenue 21221

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 6-5-1906
9. AGE (In years last birthday): 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Balto City Sewer Dept
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Ely Whitehouse
14. MOTHER'S MAIDEN NAME: Mary Jane Hays

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW11
16. SOCIAL SECURITY NO.: 188-01-1726
17. INFORMANT: RECORDS:BCH 4940 Eastern Avenue 21224 — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — 24 hours
DUE TO

(B) ASCVD
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 4/19 19 67 to 4/20 19 67, that (I) (~~we~~) last saw the deceased alive on 4/19 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Laurice McAfee M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/20/67
23C. PHYSICIAN'S NAME (Type): Dr. Laurice McAfee M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Avenue 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4-22-67
24C. NAME of CEMETERY or CREMATORY: Milwaukee Cemetery
24D. LOCATION (City, town, or county) (State): R D Clark Summit Penna

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: R. E. Fahrney
25C. FUNERAL DIRECTOR: Lozing Byers — ADDRESS: 8728 Liberty Rd Randallstown

VS 150-REV. 1/1/65

1
F-212

67 3988

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3988

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE C. FISCHBACH

2. DATE AND HOUR PRONOUNCED DEAD: April 17, 1967 1:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-09

D. STREET ADDRESS (If rural, give location): 613 S. Eaton Street # 21224,

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	July 15, 1908.	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ass't. Engineer	Gas and Elec. Co.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Andrew Fischbach

14. MOTHER'S MAIDEN NAME: Elizabeth Schoenhaar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-05-6129

17. INFORMANT: Anna M. Fischbach ADDRESS: Same.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/18/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-21-67

23C. NAME of CEMETERY or CREMATORY: Sacred Heart Cemetery

23D. LOCATION (City, town, or county) (State): 7401 German Hill Rd. Ba. Co., Md

24A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

24B. NAME OF REGISTRAR: D. A. C. Fa[illegible], M.D.

24C. FUNERAL DIRECTOR: Charles S. Zeiler, 901 S. Conkling St. Balto., 21224, Md.

VS 151-REV. 1/1/65

1 9 6 7 0 0 0 3 9 8 8

T-460

BIRTH NO. 67 3989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3989

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TAYLOR, JOHN Lewis

2. DATE AND HOUR OF DEATH: 4/21/67 12:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME AND HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD ~~60~~

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 12 27-48

D. STREET ADDRESS (If rural, give location): 1002 WOODSON ROAD

35

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8/17/91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B&O Railroad: Officer

10B. KIND OF BUSINESS OR INDUSTRY: Auditor of Disbursements

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: LEWIS B. TAYLOR

14. MOTHER'S MAIDEN NAME: MARGARET HOUCK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705 05 8484

17. INFORMANT: CHART Mrs Emilie H. Taylor — ADDRESS: same

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X1

CAUSE OF DEATH

(A) RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO

(B) Old Congestive heart failure

DUE TO

(C) and hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): ✓

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 4/16/ 1967 to 4/21 1967, that (I) (we) last saw the deceased alive on 4/21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: A. Malmin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓

23B. DATE SIGNED: 4.21.67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 4-24-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc — ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

1967 0 0 3 9 8 7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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A-163

BIRTH NO. 67 3990

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3990

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EDWARD J. AUFFARTH

2. DATE AND HOUR PRONOUNCED DEAD: April 19, 1967 1:28 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21224 1-02
D. STREET ADDRESS (If rural, give location): 529 S. Decker Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: March 10,1902.
9. AGE (In years last birthday): 65 ~~XXX~~
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10B. KIND OF BUSINESS OR INDUSTRY: Winstons Steak Pub
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Auffarth
14. MOTHER'S MAIDEN NAME: Henrietta Schaefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-01-2911
17. INFORMANT: Miss Amelia Popoli
ADDRESS: (SAme)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 422.1
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 4/20/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/24/67.
23C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS:

VS 151-REV. 1/1/65

1967 0003998

W-160

BIRTH NO. 67 3991

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3991

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GERMANUS G. WEBER

2. DATE AND HOUR PRONOUNCED DEAD: 4-23-67 4:00 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 715 S. GRUNDY STREET - Amb. Crew #2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 715 Grundy Street 21224

26-09

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/4/06
9. AGE (In years last birthday): 62
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Checker
10B. KIND OF BUSINESS OR INDUSTRY: Moore McCormick
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Weber
14. MOTHER'S MAIDEN NAME: Gertrude Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W.II
16. SOCIAL SECURITY NO.: 216-09-8369
17. INFORMANT: Mrs. Catherine Weber ADDRESS: 715 S. Grundy

MEDICAL CERTIFICATION

18. 443 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Hypertensive and arteriosclerotic cardiovascular disease

DUE TO XXXX

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R S Fisher M.D.
EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-24-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 4/26/67
23C. NAME of CEMETERY or CREMATORY: Gardens of Faith
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
24B. NAME OF REGISTRAR: Robert E. Fisher
24C. FUNERAL DIRECTOR: Joseph N Zannino
ADDRESS: 263 S Conkling St Balto Md

VS 151-REV. 1/1965

67 003999

SAB-48-38-92 15-530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3992 Registered No. 67 3992

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Catherine Smith

2. DATE AND HOUR OF DEATH: 4/22/67 8 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-10
D. STREET ADDRESS (If rural, give location): 229 South Bouldin Street 21224

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: 10-14-1894
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George
14. MOTHER'S MAIDEN NAME: Sophie Buczkowski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records: BCH-4940 Eastern Avenue ADDRESS: 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 175.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of
DUE TO
(B) Ovary, metastatic
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/28 1966 to 4/22 1967 that (I) (we) last saw the deceased alive on 4/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N J Owellen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/22/67
23C. PHYSICIAN'S NAME (Type): N.J. Owellen M.D.
23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/25/67
24C. NAME of CEMETERY or CREMATORY: Oaklawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Fankow
25C. FUNERAL DIRECTOR: Joseph Zannino
ADDRESS: J. Zannino 263 S. Conklin St.

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
A-130

BIRTH NO. 67 3993

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3993

1. NAME OF DECEASED (Type or Print): JOSEPH P. ABBATO JR.

2. DATE AND HOUR PRONOUNCED DEAD: April 19, 1967 | 4:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1218 St. Paul Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 1218 St. Paul Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: July 1, 1933

9. AGE (In years last birthday): 33

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph P. Abbato

14. MOTHER'S MAIDEN NAME: Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 219-28-8905

17. INFORMANT: Joseph P. Abbato ADDRESS: - 5310 Goodnow Rd.

MEDICAL CERTIFICATION

1B. 7953

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cause of Death Undetermined at Autopsy and Toxicologic Examination.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? b Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4/20/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 4-24-1967

23C. NAME of CEMETERY or CREMATORY: Baltimore National

23D. LOCATION (City, town, or county) (State): Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

24B. NAME OF REGISTRAR: Robert E. Farber M.D.

24C. FUNERAL DIRECTOR: Ellsworth Armacost ADDRESS: - 4600 Liberty Hghts.

VS 151-REV. 1/1/65

1967 0004001

G-264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3994 Registered No. 67 3994

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edwin L. Gisriel

2. DATE AND HOUR OF DEATH: April 19, 1967 | 7:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02

D. STREET ADDRESS (If rural, give location): 3113 St. Paul St.

5. SEX: Male

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced

8. DATE OF BIRTH: 3/31/00

9. AGE (In years last birthday): 67.

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Gisriel

14. MOTHER'S MAIDEN NAME: Grace Knowles

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): -No-

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-01-2406

17. INFORMANT: Ruth Muir Mrs ~~Verna Gaskey~~ 4530 N. Charles

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

490X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) (1) Bilateral Lobar Pneumonia.

(B) (2) Purulent Meningitis (pneumococcal).

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 4/18 1967 to 4/19 1967, that (I) ~~(we)~~ last saw the deceased alive on 4/19 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Nat E. Watson, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): NAT E. WATSON, JR., M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 4-22-67

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Ellsworth Armacost

ADDRESS: 4600 Liberty Heights

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B. 626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3995 Registered No. 67 3995

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Martha E. Borchers

2. DATE AND HOUR OF DEATH: 4-23-67 | 5:50 pm M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GOULD CONVALESCARIUM 90 6116 Belair Rd Balto 21206

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Rural 53-00

D. STREET ADDRESS (If rural, give location): 7001 Kinsdale Ave Balto 21206 Md

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 19 May 1883

9. AGE (In years last birthday): 83

(If Under 1 Yr. Months Days) (If Under 24 Hrs. Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOK Keeper

10B. KIND OF BUSINESS OR INDUSTRY: L. E JONES WIRE + IRON WORKS

11. BIRTHPLACE (State or foreign country): Chestertown Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JAMES CURRAN

14. MOTHER'S MAIDEN NAME: SARAH REED

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 212-12-4039

17. INFORMANT: Catherine E. Wyatt ADDRESS: 7001 Kinsdale Ave

MEDICAL CERTIFICATION

18. 4 22.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Atherosclerotic Cardio — INTERVAL BETWEEN ONSET AND DEATH: Uncle Terminal

DUE TO

(B) vascular Disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from "Spring" 19 65 to 4-23 19 67, that (I) (we) last saw the deceased alive on 4-22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: John C. Hyle M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 4-23-67

23C. PHYSICIAN'S NAME (Type): JOHN C. Hyle M.D.

23D. ADDRESS: 7527 Belair Rd

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: APR 26 67

24C. NAME of CEMETERY or CREMATORY: HOLY REDEEMER CEM.

24D. LOCATION (City, town, or county): 4430 BELAIR ROAD (State): MD

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967

25B. NAME OF REGISTRAR: Robert E. Fabian M.D.

25C. FUNERAL DIRECTOR: DIPPEL BROS INC ADDRESS: 7110 BELAIR ROAD

VS 150-REV. 1/1/65

1003

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D. 262

BIRTH NO. 67 3996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 3996

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DICKERSON WILLIAM M.

2. DATE AND HOUR OF DEATH: 4. 21. 1967 | 11.05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSP

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: 605
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 14. N. Ann St. 21231

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: June 25 1998
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED TRUCK DRIVER
10B. KIND OF BUSINESS OR INDUSTRY: SELF
11. BIRTHPLACE (State or foreign country): WILLIS VA
12. CITIZEN OF WHAT COUNTRY? AMR.

13. FATHER'S NAME: UNK DICKERSON
14. MOTHER'S MAIDEN NAME: ELIZABETH HILTON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 218-09-6870
17. INFORMANT: CHURCH HOME & HOSP
ADDRESS:

MEDICAL CERTIFICATION

18. 4.20.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Edema & Acute M.I. and Hypertrophy — Few hours.

DUE TO

(B) Hypertension & — many years.

DUE TO

(C) Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4. 21. 1967 to 4. 21. 1967, that (I) (we) last saw the deceased alive on 4. 21. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Susarey M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/22/67

23C. PHYSICIAN'S NAME (Type): Renita Susarey M.D.
23D. ADDRESS: Church Home & Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: APR 24 1967
24C. NAME of CEMETERY or CREMATORY: OAK LAWN CEMETERY
24D. LOCATION (City, town, or county): EASTERN AVE BLVD (State): MD.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Ralph E. Farley M.D.
25C. FUNERAL DIRECTOR: DIPPEL BROS INC
ADDRESS: 1800 E LOMBARD ST

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

G.426
M.224

67 3997

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 3997

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY GILCHRIST AKA John Doe McCaskill

2. DATE AND HOUR PRONOUNCED DEAD: April 19, 1967 4:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 704
D. STREET ADDRESS (If rural, give location): 903 Shuter Street

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Not known
8. DATE OF BIRTH: Nov. 6, 1923
9. AGE (In years last birthday): 43
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Shipyard
11. BIRTHPLACE (State or foreign country): N C
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: JAMES
14. MOTHER'S MAIDEN NAME: HALLIE BOYED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jones
ADDRESS: 818 4th St. N.E. Washington DC

MEDICAL CERTIFICATION

1B. 490 X 260 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Malnutrition, Diabetes, Fatty liver

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes - Partial
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R W Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

DATE SIGNED: 4-19-67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: April 24, 1967
23C. NAME of CEMETERY or CREMATORY: Local
23D. LOCATION (City, town, or county) (State): Cheraw S. Carolina

24A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Joseph L. Russ
ADDRESS: 2222 W. North Ave. Baltimore, Md.

VS 151-REV. 1/1/65

1967 0004005

W-340
W-340

BIRTH NO. 67 3998

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 3998

1. NAME OF DECEASED (Type or Print): LILLIE H. WHITELY or Whitley

2. DATE AND HOUR PRONOUNCED DEAD: 4-20-67 | 9:15 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2007 MADISON AVENUE - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2007 Madison Avenue 21217

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Colored		3-10-1894	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Own home	Richmond, Va.	U.S.A.

13. FATHER'S NAME: Henry T. Briggs

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-12-3957

17. INFORMANT: Mrs Mabel Pervis | ADDRESS: 1804 E. Lafayette Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection [X] Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes [X] Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 4-21-67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	4-24-67	Mt. Calvary Cemetery	Anne Arundel Co. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
APR 24 1967	Robert E. Farley M.D.	Randolph J. Cedlick	243 E. Oliver St.

VS 151-REV. 1/1/65

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 3999 Registered No. 67 3999

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GUYAS, ALEX (NMI)

2. DATE AND HOUR OF DEATH: 22 April 67, 4 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEMORIAL HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: ~~Baltimore~~
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21214 27-03
D. STREET ADDRESS (If rural, give location): 3319 RUECKERT AVE

5. SEX: M
6. RACE: W
7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify)): MARRIED
8. DATE OF BIRTH: 04-28-95
9. AGE (In years last birthday): 71
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-- Barber
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): HUNGARY
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: LEWIS GUYAS
14. MOTHER'S MAIDEN NAME: UNKnown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No ~~XXXXX~~ (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 175-20-0867
17. INFORMANT: Mrs. Elizabeth Guyas
ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 204.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute granulocytic leukemia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 04-03-67 19 to 04-22-67 19, that ~~(I)~~ (we) last saw the deceased alive on 04-22-67 19 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 22 April 67
23C. PHYSICIAN'S NAME (Type): DR SIDNEY E KIRKLEY M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/25/67.
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS

VS 150-REV. 1/1/65

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 4000 Registered No. 67 4000

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARTIN H. BIEN

2. DATE AND HOUR OF DEATH: 4/20/67 7:31 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Mem Hosp 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: ~~Balt~~
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt 27-38
D. STREET ADDRESS (If rural, give location): 2001 Ranblewood Rd

5. SEX: M.
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 10/18/89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Cont. Can Co.
11. BIRTHPLACE (State or foreign country): ~~[illegible]~~ Maryland
12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Henry Bien
14. MOTHER'S MAIDEN NAME: Catherine Denges.

15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-03-3729A
17. INFORMANT: Mrs. Margaret K. Bien
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ? Intracranial Lesion
DUE TO
(B) ? cerebro vasc. accident
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/9/67 19 to 4/20/67 19, that (I) (we) last saw the deceased alive on 4/20/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert Doyle M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 4/20/67
23C. PHYSICIAN'S NAME (Type): Robert R. Doyle M.D.
23D. ADDRESS: Union Mem Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 4/24/67.
24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: APR 24 1967
25B. NAME OF REGISTRAR: Robert E. Fackenthal
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto Md. 21214
ADDRESS

VS 150-REV. 1/1/65

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.